Stop the Tears

Final Report

A Report of the 1987 Missouri
Blue Ribbon Commission on the Future of Services
to Children and Families

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The Department of Social Services Blue Ribbon Commission on the Future of Services to Children and Families

was appointed on July 16, 1987, by Dr. Michael V. Reagen, director of the Missouri Department of Social Services, to analyze the future of services to children and families.

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SUMMARY

By 1986, nearly 80,000 Missouri children of both sexes, all races and every socioeconomic class inherited a legacy of child abuse or neglect. Our response to this extensive, insidious problem has been inadequate. Practically no state funds are allocated for prevention of child maltreatment. Instead, treatment services for abused or neglected children consume most of the state resources spent on this problem. However, many abused or neglected children and their families never receive the services to which they are entitled. This commission advocates an increase in funding that would allot monies for prevention. We also recommend funding reallocations so that all families weakened by child abuse or neglect would receive treatment services for both children and adults to enable the family to be preserved or reunited.

Our report consists of a preface, introduction, and three-part body, together with an appendix and bibliography. The body of the report outlines the impediments to prevention of child abuse or neglect in Missouri and the reasons why treatment services in this state are inadequate. We support our contentions with case reports. We also cite some instances of successful intervention to illustrate how these problems and impediments might be overcome. In addition, we present our ideas about what the future would be like if our recommendations are followed.

In Part I, we show how our failure to prevent abuse or neglect is killing or crippling Missouri children. Severely injured children who survive maltreatment often must spend the rest of their lives in institutional settings. Not only is such an environment often grossly inappropriate for a child's nurturance, it is expensive. Missourians pay upwards of $2 million in tax dollars for the lifetime care of each severely injured child. Failure to prevent abuse or neglect costs everyone, especially the children who sustain crippling physical injuries and devastating emotional loss.

Prevention can take many forms and occupy levels from grassroots community organizations to the highest state government offices. However, this invaluable approach is not consistently encouraged nor adequately funded in Missouri.

Furthermore, families and children often do not get the kinds of treatment services they need and to which they are entitled by state statute. Such gaps in the continuum of care often begin when families enter the system via the Missouri Child Abuse & Neglect Hotline. The Division of Family Services (DFS) often does not provide consistent evaluations of, or comprehensive treatment plans for, maltreated children. Such children, often inadequately monitored, do not receive appropriate treatment. Furthermore, there is a lack of permanency planning for such children, resulting in an inappropriate out-of-home placement or causing them to languish within the limbo of prolonged foster care. Foster families often feel victimized by the system, especially when they must pay out-of-pocket expenses for medical care or day care that are unreimbursable.

At its worst, the system fails maltreated children and their families, not because of malevolence, but because of policies that impede delivery of services. DFS does not institute long-range planning so that families who need services are ensured of receiving them. The often high staff turnover within DFS, and its image of "service to the poor", further impede the process of service delivery. Since many treatment services are purchased from vendors, there needs to be a consistent and fair method of reimbursing these contract providers. The present system, not characterized by such traits, is therefore not cost effective.

Our highly reactive current system of child protection lacks an orientation toward family preservation. The current system of service purchase promotes the breakup of families and often does not promote family reunification. Consequently, children are caught in a web from which there is little chance of escape.

In Part II of this report, we outline measures that can brighten this dismal picture. We show how prevention programs can be widely effected, encompassing education, support, coordination, legislation and evaluation. This commission's primary recommendation centers around improved prevention efforts that begin in state government. Specifically, we propose a new model for state government, as outlined in Part II, that includes a prevention coordinator and prevention specialists.

Closely following upon our prevention recommendation, we encourage Missouri to provide a continuum of care focused on evaluation of children and coordination of services. In Part II, we describe how to improve current services for children. Such improved services would result from better functioning of the hotline, which we outline in specific detail. We also provide recommendations on how to improve other aspects of service delivery, such as how to keep children moving through the system, and how DFS might improve their system of service purchase.

Although many of our recommendations do not require more monies, some programs — especially those focused on prevention — will need a strong funding base in order to be successfully implemented.

Education of all segments of the population with respect to what constitutes abuse or neglect, and the basics of child growth and development plus appropriate parenting practices that include non-violent discipline measures, will help to make prevention of child maltreatment a reality. However, such an educational effort will require adequate support for such prevention programs — tangible support that provides resources to parents, children and professionals.

In summary, Missouri must make prevention of child maltreatment a government priority. In addition, DFS must deliver services that provide a continuum of care for children and their families. Although service delivery to children is paramount, DFS must institute a system whereby such service delivery occurs in the context of family preservation. Both of these efforts require adequate monies.

Such sweeping changes can result from adequately supported reforms encompassing community groups at the grass roots level to the highest levels of state government. Preventing child abuse or neglect is the responsibility of every citizen, not just employees of the state or its agencies. It can only be accomplished by an integrative, multi-faceted approach as we outline in our report.

In Part III, we describe what such pervasive changes can do for Missouri's children and families. To put family needs in context, we describe how changes in family structure and in society have conspired to weaken families. Those traits that characterize a healthy family are described. We show how child abuse or neglect often occurs when weakened families do not receive the right kind of help to effectively overcome their problems.

Although this commission consists of members with diverse points of view, we are united in our belief that prevention of child maltreatment must be the state's top priority. We show how prevention of child abuse or neglect is the more cost-effective approach.

Finally, we demonstrate how the right kind of state government and appropriate policy changes can produce a real continuum of care consisting of better programs and services that promote family preservation.

Such an approach, focusing on prevention and better service delivery, will greatly strengthen the family in Missouri. With stronger families will come a decrease in the many societal problems — adolescent pregnancy, drug abuse, and mistreatment of our elderly — with which we also struggle.

PREFACE

Twenty-five years ago, most people found it unthinkable that families could mistreat their children, much less kill them. However, as media reports continually indicate, child abuse and neglect are alarming realities.

In 1975, the Missouri legislature enacted a statute that obligated child abuse or neglect to be reported. This statute — clearly and powerfully written — signals Missourians' commitment to provide endangered children with an opportunity to grow up in a nurturing environment that promotes their potential. Despite this noteworthy legislative advance, there continues to be a dramatic annual increase in the numbers of Missouri children who are maltreated. In the 12 years since this legislation was enacted, over 600,000 Missouri children have been reported as abused or neglected.

When the legislature embraced this commitment to help abused or neglected children, no one realized how enormous the problem really is. Thus, no one realized how costly and difficult it would be to implement the remedy. Since 1975, a system to help abused and neglected children has evolved. This system places most of the responsibility on the Division of Family Services (DFS) of the Department of Social Services (DSS). Other departments and divisions are also involved, as well as other branches of state government: law enforcement, juvenile courts, and health agencies. In 1987, almost 60,000 children will be served in the child welfare system.

Over the years, most programs for helping abused or neglected children have developed in reaction to crises. Some policies, procedures and mechanisms prevent children from getting what they really need. Such entrapments sometimes place mistreated children in "Catch-22" mazes. There, system components lack consistent quality, planning or communication; sometimes, services may be unavailable. Beyond their disservice to children, such system flaws waste money. For lack of preventive and early treatment services, problems worsen, leading to disruption of the family and costly out-of-home placements of children.

This Blue Ribbon Commission on the Future of Services to Children and Families was convened to examine current and future services for Missouri's families and children who are caught in a cycle of child abuse or neglect. But, in many cases, the data necessary for analysis and planning are insufficient or absent. In approaching this task, we have the benefit of viewing over a decade of experience, plus the ready cooperation of DFS. DFS has provided information that documents the system's efforts to protect children, both its failures and its successes. Nonetheless, DFS' openness and cooperation have required a large measure of courage. But even more, it reflects their commitment to better serve Missouri's children.

Let there be no misunderstanding, however, as to where the responsibility falls when it comes to the protection of children. Dealing with child abuse or neglect is not just the responsibility of DSS or DFS. Protecting children is the responsibility of each citizen.

With this philosophy, this commission has examined Missouri's current programs for helping abused or neglected children. The focus, outlined fully in this report's appendix, can be summarized by considering three areas on the continuum of services for children: prevention, delivery of service to abused or neglected children who remain in their homes, and delivery of services to children who must be removed from their homes.

Although this commission places top priority upon Missouri's children, we realize that the family is the fundamental unit where a child is nurtured. When it is strong, the family can best provide the love, support and encouragement that lead to a child's fulfillment. To that end, most of our recommendations focus on strengthening the family, keeping it intact, and making it as self-sufficient as possible. But when the family falters, we acknowledge the necessity for remedies to either rebuild the family or to find a new environment where the child can grow.

The families who are described herein are real. But their names, as well as some details of their cases, have been changed or omitted in order to safeguard their privacy, except in those instances where their identity is a matter of public record. The case reports herein all depict Missourians. Their children are Missouri's children. Their problems belong to us because how they are solved affects our common stake in the future.

This report marks a beginning, the start of an open process to critically examine what is and is not being done and to change the direction for services to abused and neglected children in the future. This report is also unique. It is a first; there has never been anything like it in Missouri's history of helping abused or neglected children. Given our short time for study and incomplete information, it is likely to have imperfections. But if we are to succeed, the cooperative effort that produced this report must persist. We must continually evaluate, plan and redirect our efforts. Without such a process, the system has no eyes to see our way to the vision of the future.

INTRODUCTION

In November 1987, the nation's attention was riveted on New York, the home of Elizabeth Steinberg. There, amid the glare of media attention and with hundreds of strangers in attendance, six-year-old Lisa, as she was called, was buried. Lisa was found comatose and brain dead on November 2 in the apartment of her adoptive father, Joel Steinberg. He and his common-law wife, Hedda Nussbaum, were charged with Lisa's murder. The caption beneath Lisa's picture in the November 13 issue of the *St. Louis Post-Dispatch* read, "Victim of Abuse."

Media reports indicate that neighbors often heard screams coming from the apartment where Lisa lived. *USA Today* reports that "...police found Lisa beaten senseless in a filthy... apartment. Her adoptive brother, Mitchell, 16 months, was found in his own excrement." According to other information in the story, police and social service workers had been called to investigate conditions at Lisa's home when lawyer Steinberg, 46, and children's books author Nussbaum, 45, were reported. Perhaps Lisa's adoptive parents evaded the system because their profile — upper middle class, well educated, Jewish and middle aged — do not fit the stereotype of the typical child abuser.

Could such an incident happen in Missouri? Indeed, it not only could, but does happen.

Cathy

Nearly four years before Lisa's funeral in New York, a baby girl was born in rural Missouri to a married couple. Although baby Cathy's parents were both young (19 years-old) and had been married for only three months, their families supported them in traditional fashion — the couple lived in a house owned by relatives and the young father worked on his brother's farm. Cathy's mother had dropped out of high school to care for her baby, but Cathy's father was finishing his education. Though not an ideal situation, perhaps, there was nothing to indicate that Cathy might be in jeopardy.

One day, Cathy's mother went shopping, leaving the three month old baby girl in the care of her father. Although no one knows what caused Cathy to stop breathing while she and her father were alone, hospital records indicate that the baby was brain dead by the time she reached the hospital.

> "...Some people get crushed by their families. Others are saved by them."
>
> — Peter Collier

X-rays showed that Cathy had four rib fractures in various stages of healing, indicating that they had occurred over a protracted period of time. X-rays also showed that around Cathy's left wrist, there was a twisting injury that was about the same age as the rib fractures. Her new injuries included a dislocated neck, a retinal hemorrhage, and brain swelling and hemorrhage. These new injuries documented that in all likelihood, Cathy had

been beaten and shaken to death.

Although this circumstantial evidence led authorities to believe that Cathy had been murdered by her father, he was never prosecuted, nor was he ever given any instructions on infant care and development that would prevent this from happening again when he sires other children. At most, when he abuses his next child, his probable role in Cathy's death will be another piece of data on his record. More likely, it will be judged inadmissible and suppressed.

In cases like Cathy's, child abuse is difficult to predict. There are risk factors, such as parental immaturity or lack of education or family poverty. But not all youthful parents who are poor and uneducated will abuse or neglect their children. Indeed, child abuse or neglect can occur in well-to-do families such as Lisa's.

To begin to attack this problem, we must first define the problem. According to Missouri's Child Abuse & Neglect Law, "abuse" of a child constitutes any physical injury, sexual abuse or emotional abuse that is inflicted non-accidentally by any of a child's caretakers. Under this law, spanking — "administered in a reasonable manner" — is not considered abuse.

The same law defines child neglect as failure to provide a child's proper or necessary support, education, nutrition, or medical, surgical or other care necessary for a child's well-being.

In 1986, there were 43,102 instances of child abuse or neglect reported in Missouri; these reports involved 77,481 children.

In October 1987, there were 14,339 families in Missouri with 31,628 children in the protective services system of the Division of Family Services (DFS). Currently, 4,352 families with 9,699 children are in protective services in St. Louis City and County. In addition, approximately 2,100 children are in foster care.

Children entering the St. Louis foster care system will remain an average of three years. One out of two foster children will stay more than two years. Generally, they will be transferred to several homes and have numerous social workers.

Since abuse or neglect follows a continuum of severity, ranging from none to mild or moderate to fatal, there must be a concomitant continuum of response. When the system completely fails to prevent abuse or to intervene early, there are several consequences: in about 0.5 percent of cases, severe injury or death of children occurs. In about 15 percent of reported cases, the family is dissolved, at least temporarily. Although Cathy's family never entered the criminal justice system, our society does provide legal remedies — incarceration of the perpetrators and criminal prosecution.

Where do families in trouble turn for help? Often, they turn inward, remaining isolated and becoming more unhappy. When they seek help from institutions, it is often the private sector — churches and volunteer organizations — that come to their assistance. Governmental agencies are another major resource for families in trouble. How families are served by these agencies, most notably DFS, is the focus of this report.

The Division of Family Services' Children's Services program is one of the primary state agencies responding to families and children in need of protection. DFS intervenes when an incident of abuse or neglect is reported, a child has committed a status offense, or a child or family has experienced other kinds of emotional trauma. Thus, DFS answers many needs, not just those of families where child abuse or neglect is an issue.

One of DFS' goals is the prevention of unnecessary separation of the child from its

natural family. In the event that the child must be removed from the family, then DFS seeks permanent placement for the child through subsequent reunification with parents, adoption or other permanent living arrangements.

Programs

DFS provides eight programs or services as described in this report's appendix. These are:

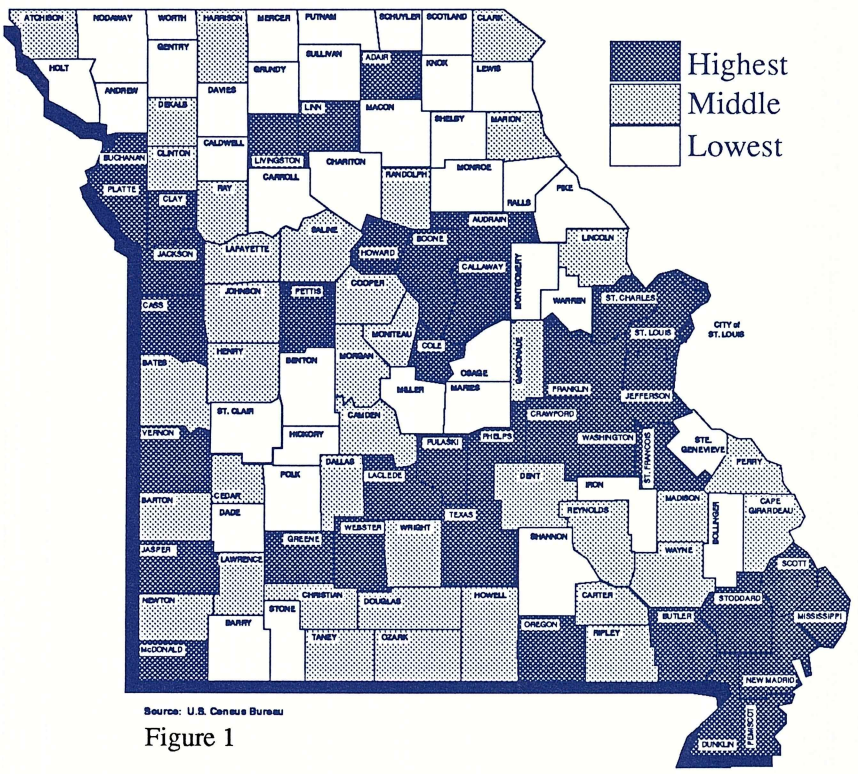
- **the Child Abuse & Neglect Hotline** to enable reports of suspected abuse or neglect to be made by observers;
- **protective services** for children still in the family home who are believed to need help because of a report of suspected abuse or neglect;
- **safekeeping services** for children whose family requests assistance;
- **alternative care services** when a child must be placed outside the family home;
- **adoption services** focused primarily on children with special medical or behavioral problems who have been in foster care;
- **problem pregnancy services** for women who need assistance;
- **independent living services** for the older child making the transition to adulthood; and
- **day care services** for children in three targeted groups.

In summary, DFS provides programs and services aimed at serving families whose children are in jeopardy because of financial stress and/or emotional problems.

This commission recognizes that DFS has been unable to stem the rising tide of child abuse and neglect. Child abuse and neglect are growing problems that are not being effectively prevented or treated by the present system in Missouri. In this report, we describe current dilemmas and possible remedies in order to reduce or prevent child abuse or neglect. We also describe those instances of creative thinking and cooperation where success demonstrates that problems can be surmounted and are not irreversibly crippling.

The strong system of extended families that once helped young parents cope with the demands of rearing children has disappeared. In place of the family headed by two parents who were married to each other, with relatives nearby to assist, a substantial number of Missouri families may be headed by single parents. Figure 1 depicts how Missouri single-parent families are distributed by county.

Percent of Single Parent Households 1980

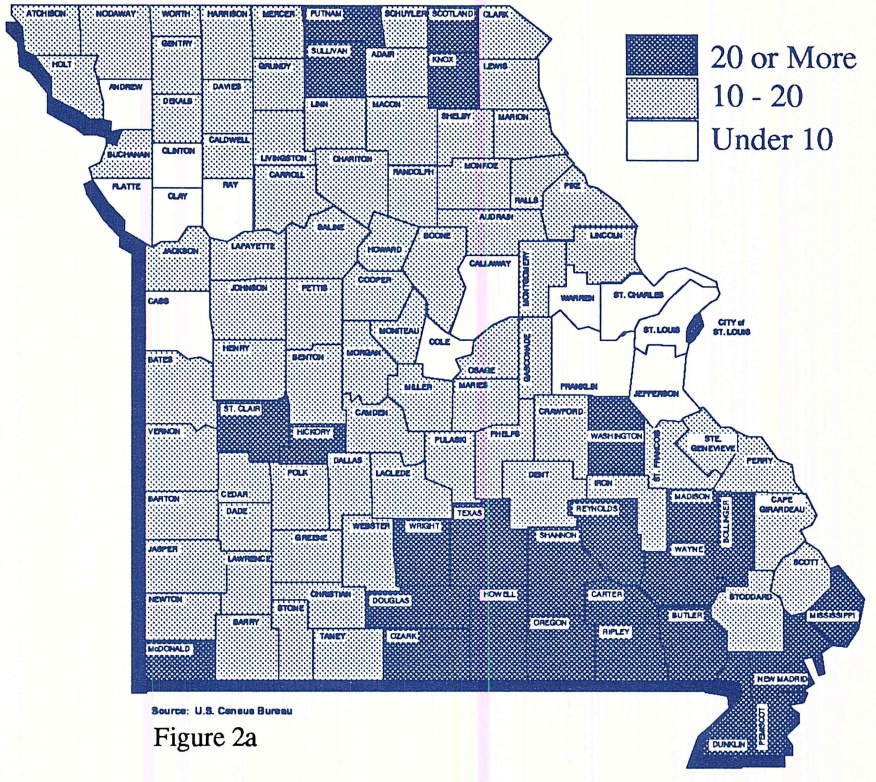


Source: U.S. Census Bureau

Figure 1

Single parent families are often isolated from supportive relatives or neighbors. Frequently, the single parent has to cope with the demands of rearing children while unable to

Percent of Persons Below the Poverty Level
1980



Source: U.S. Census Bureau

Figure 2a

provide for the family's economic needs. This climate tends to stress families, not nurture them. Such a conclusion is supported by the information presented in Figures 2a and 2b, where the counties most affected by poverty are often the regions where the largest numbers of abused children reside. Overall, 20 percent of Missouri's children live in poverty.

Children reared in healthy families will receive the emotional support and physical requirements to grow into productive adults. Yet this is unlikely to happen when adult members of a family do not have their own emotional and physical needs met. Instead of receiving nurturance, children often bear the brunt of the adult family members' frustration and despair. Abused children are denied the very affirmation that they are worthwhile persons, so necessary for self-esteem to bloom. Instead, their sense of trust in others is violated, they are not infused with a zest for life, and they do not learn to respect themselves or others.

That our hunger for intimacy is unmet in the family is only too apparent from the rising incidence of divorce, drug abuse (including alcoholism), and child abuse or neglect. These problems cut across all racial and economic classes. They affect families at all levels of income, families who live in rural and urban areas, and families consisting of two parents or

Suspected Victims of Child Abuse 1985
Per 1,000 Children

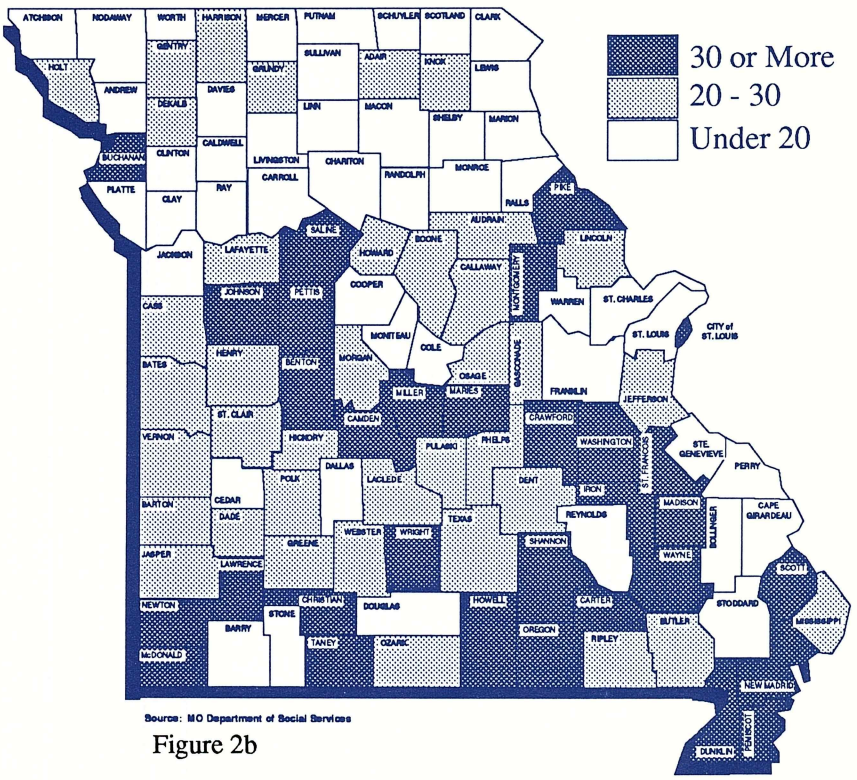


Figure 2b

single parents.

This commission does not advocate a blanket remedy as simple as an increase in funding. Although the new programs that are suggested will entail new funding, we also present many ideas that will refocus programs or reallocate funds that are currently misdirected. We point out crippling policies, when they exist, and describe how to remedy them through better legislation.

Commission members are unanimous in our call for preventive measures to become a major thrust of the department's efforts. Although incidents of child abuse or neglect must continue to be treated through appropriate programs or remedies, we believe that the best course is to intervene before a family deteriorates. Prevention is not only the most cost-effective approach in terms of dollars, it also avoids untold human suffering and death.

This commission advocates the philosophy that the best place for a child to grow up is with a real family — its own natural family, when possible. Thus, preservation of the family should be the division's goal, when in the best interests of the child.

Occasionally, a parent cannot be rehabilitated, despite the efforts of DFS and others. In those cases, a timely remedy should be provided to save these children from the limbo that prevents them from finding permanent homes.

Part I

Failing to Meet the Needs of Missouri's Neglected or Abused Children

A. Failure to Prevent Abuse or Neglect is Killing Our Children

As a society, we know more about the cars we drive than the well-being of our children. We are more restrictive about who can own or drive a car than about who can take on the most demanding of all tasks — parenting. In order to operate a vehicle, a driver must obtain and periodically renew a license, present the vehicle for periodic inspections, and demonstrate proof of adequate insurance. Yet no central registry documents who is caring for our children, or maintains a list of children's deaths and their circumstances. Until the age of six, when they enter school, children in our society are relatively invisible.

1. Children Need Protection

Although their social visibility improves at age six, children remain politically invisible until they reach adulthood. Unlike any other segment of our society — even groups traditionally considered downtrodden — children do not vote nor have lobbying power. In short, they have no political clout. Protecting children, assuring their health and well-being, is therefore the responsibility of adults.

2. Children Die from Abuse and Neglect

It has become clear during the past two decades that growing numbers of children, of both sexes, of all ages and races, and from every income level and geographic area fall heir to child abuse or neglect. National and statewide reports substantiate this perception. In 1976, the Clearinghouse on Child Abuse and Neglect Information, United States Department of Health and Human Services, reported that 669,000 children were abused or neglected. By 1984, the number escalated to 1.727 million — triple the number in only eight years.

Statistics do not indicate how many children in Missouri were actually abused or neglected in 1976, they only indicate the number of reports received (13,220). By 1984, the number of reports had escalated to 39,713 — a three-fold increase. These 39,713 reports involved 72,446 children. Of these 39,713 reports investigated by DFS, almost half (17,395) were judged "reason to suspect." The latter term means that in the judgement of the investigator, the children had been maltreated or were in danger of being maltreated[1]. These

[1]Hereafter in this report, the term "substantiated" is used instead of the official term "reason to suspect." In fact, only courts substantiate abuse or neglect; DFS determines only that there is sufficient reason to believe that a report has merit thus allowing DFS to become involved. However, in popular usage, the term substantiated is used to indicate DFS' determination of reason to suspect.

substantiated reports involved 30,907 victims — 2.8 percent of our children. They also verified at least 31 deaths of children in this state from abuse. No one knows how many children survive, irreversibly disabled by their injuries, nor how many incidents of abuse or neglect went unreported.

Because of the alarming rise in reports over the past decade, as shown in Figure 4, it is tempting to conclude that child abuse and neglect are on the increase. They are not new problems. This commission believes that these problems have been with us always. What has changed is that we are uncovering more abuse or neglect because of laws that require reporting and because of media attention. However, beyond this heightened awareness, increased family stresses like poverty have increased the incidence of severe child abuse.

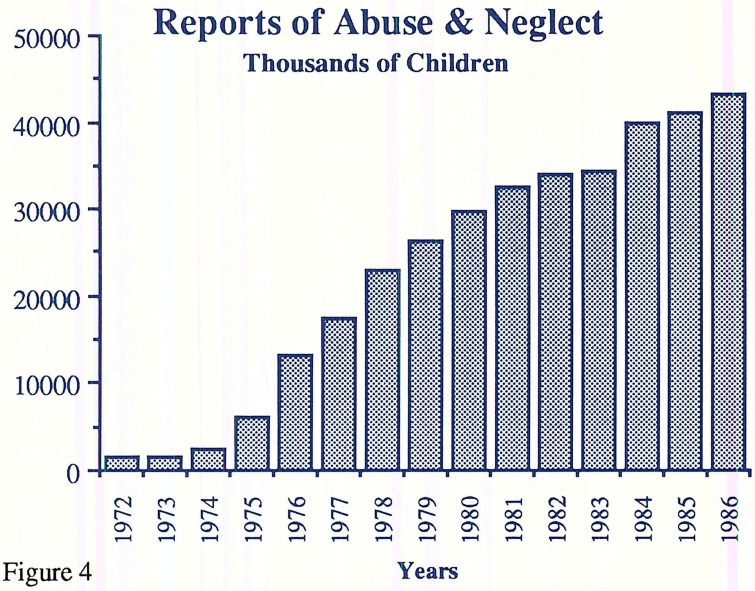


Figure 4

The National Committee for Prevention of Child Abuse (NCPCA) says that from 1984 to 1986, 34 states reported that 1,845 children died as a result of abuse or neglect. Furthermore, NCPCA's statistics indicate a 23 percent increase in the reported number of deaths from child abuse between 1985 to 1986.

At least 73 of these child deaths occurred in Missouri during the three years of 1984 through 1986. On August 7, 1987, the prevention subcommittee of this commission heard testimony from a panel of experts that indicated about half of these children died from abuse. The other half died as a consequence of neglect. Infancy — from birth to the child's first birthday — is particularly hazardous, since 50 to 75 percent of the deaths from abuse or neglect occur in this age group. This panel further reported that between the ages of birth to one year, infanticide is the sixth leading cause of death of children in our country.

Although the age range of those who murder children is wide, testimony indicated that the most frequently occurring age is 19 years. About 75 percent of the persons who kill children are males. Thus, children are being murdered by children, often their own fathers or other males who are still teenagers.

Besides a parent's youthful age, another high-risk predictor for violence toward children is poverty, whether the family resides in an urban or rural environment. In the November 15, 1987, edition of the *St. Louis Post-Dispatch*, an article ("Shaky Times in the Bootheel") indicates that three counties in Missouri's "bootheel" area (extreme southeastern Missouri) — Pemiscot, Dunklin and New Madrid — are among the poorest in the state and nation. These counties display the state's highest rates for many social problems, including child abuse and neglect. According to the newspaper account, 12 percent of the residents in the bootheel counties depend on a monthly check from Aid to Families with Dependent Children — three times the state average. One in three Pemiscot County residents receives Food Stamps or welfare or both — the highest rate in the state.

Poor rural areas such as the bootheel are not the only areas where child abuse or neglect is high. In the city of St. Louis, where about the same proportion of families (12 percent)

receive some type of income maintenance, there are also high rates of child abuse or neglect (see Figure 2b).

Although not every instance of child abuse or neglect can be predicted, many easily identifiable risk factors increase the chance of child maltreatment. Families who severely abuse or neglect children often have features that are uncommon among nonabusive families. Likelihood of severe or even fatal maltreatment increases with certain family constellations. For example, when a single parent (mother) lives with a male with whom she has a sexual relationship, there is an increased chance that her children will be severely mistreated. Many families where severe maltreatment occurs have a history of adult members' previous arrests or convictions.

Severely maltreated children are fairly similar. They are young (over 90 percent are age four or younger), and most were normal before they were severely abused.

Severely abused children can die or be incapacitated permanently. Although much remains to be learned about such unfortunate children, current estimates indicate that a third of such children die, a third seemingly recover and a third are so severely handicapped that they will require nursing care for the rest of their lives.

We lack systematically collected data about children's deaths, especially those cases involving abuse or neglect. Even the annual statistics of abuse-related deaths in our state are estimates that are probably low by 50 percent. At a minimum, the death certificate in Missouri should be amended so that it can indicate whenever abuse or neglect contributes to a child's death. Only with better information will we be able to better develop and focus family support programs.

3. Severely Injured Children Live in Institutions

Care for these severely damaged abused children often cannot be provided by their natural parents or foster parents, nor can they be cared for in most residential group homes. Thus, they spend their lives in institutions. Never do they know a real childhood, a terrible price in itself, nor do they feel part of a family. The financial burden to the taxpayer is also heavy: approximately $2 million for a lifetime of custodial care.

Such a burden can be avoided when adequate efforts toward prevention become the primary focus. The lack of such preventive efforts costs money and deprives children of a normal life.

Robbie

Robbie was brought to a hospital on a raw January day by his 20-year-old mother's boyfriend. The toddler's medical report describes the bruising about his face that had produced swelling on both sides of his head. Both eardrums were perforated. Robbie was completely unresponsive, his lethargy a result of the brain damage accompanied by accumulation of blood inside his skull. Doctors found hemorrhages inside both of Robbie's eyes. Over the ensuing weeks, the extent of Robbie's brain injuries became visible on X-rays shown here (Figure 5). His brain decreased to about half of its normal size. Although he was subsequently removed from intensive care, Robbie cannot see, move, speak or understand.

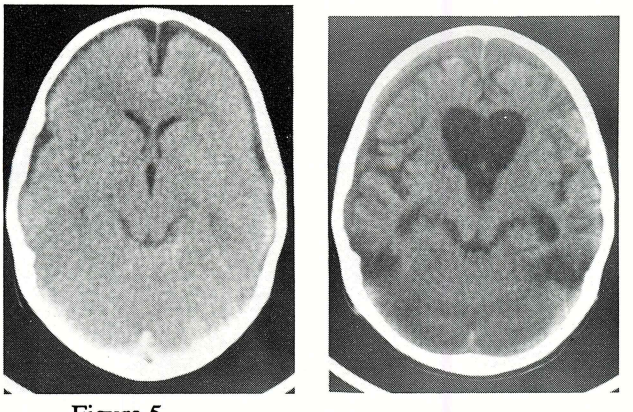


Figure 5

He will be bed-ridden the rest of his life.

Because of the severity of Robbie's injuries, DFS workers were extremely concerned that another child living in the household was at risk for equally devastating injury. In fact, Robbie's mother — who professed not to know how her son developed these life-threatening injuries — admitted that she was already "disciplining" the second child in the same way. Thus, the second child was placed in foster care.

DFS social workers believed that Robbie's mother had caused these injuries because he had to be removed from her care earlier, at age two weeks, when he had been treated for a fractured skull. In fact, Robbie had lived most of his life in foster care, having been returned to his mother by juvenile court order only a few weeks before his permanently disabling injuries occurred.

Another problem DFS workers and the courts faced was what to do about this woman's next child, due to be born in the spring. Accordingly, an evaluation of the mother's mental capacity was conducted. Robbie's mother was adjudged "borderline range of intellectual abilities," impeded by functional illiteracy and the lack of any consistent role model or parental figure in her own life.

However, even such a handicapped woman could benefit from parenting classes that include instruction on child care and appropriate non-violent discipline. Counseling and a peer group support system could have helped her overcome her mistrust, rigid thinking and self-centered perspective.

What would such early intervention have cost? Estimates place the total at around $2,000. If this seems costly, compare this with $2 million in costs to the state. This sum includes the costs of providing for Robbie's lifetime care in an institution plus the state's loss in taxes Robbie might have paid had he grown up to become a productive citizen. But the most burdensome cost of all is the fact that this tragedy could have been prevented.

B. Prevention Can Take Many Forms

Young parents are often tragically ill-equipped to care for children because they lack the most fundamental understanding of how children grow and develop. In another case of abuse reported in the November 14, 1986, edition of the *St. Louis Post-Dispatch*, a 6-month-old boy had his ribs broken allegedly by his mother's boyfriend, 18-year-old Steven T. Cooper. The boy's mother said that Cooper had told her "that the baby was 'a man and should be tough and know how to fight.'"

Although the state needs to continue its attention to treatment services for child abuse and neglect, this commission strongly endorses a vigorous effort in the broad area of prevention. Prevention of child abuse and neglect is everyone's responsibility. Prevention cannot be accomplished by any single agency or organization, private or public. To be effective, prevention efforts must reach children, families and other caregivers before abuse or neglect occurs.

In order to achieve maximum effect, prevention efforts must be integrated into existing services and education programs. Prevention programs must reach out to individual families within their homes. Furthermore, such programs must be cost-effective.

1. Three Levels of Prevention Can Be Defined

Three levels of prevention can be distinguished: primary, secondary or tertiary. Coolsen and Wechsler (1984) define primary prevention as those efforts that occur before incidents of abuse or neglect can happen. Primary prevention is aimed at positively influencing all population segments — children, parents and other caregivers. Key elements of these efforts include:

- offering prevention programs and

services to all members of a community;
- making such programs voluntary, easily accessible and free from any stigma that would discourage enrollment;
- working with and through institutions that affect adults and children; and
- promoting wellness of mind and body.

Thus, primary prevention efforts are directed at the entire population. In contrast, secondary prevention supports targeted families who are at risk. Tertiary prevention aims to prevent recurrence once abuse or neglect has already happened.

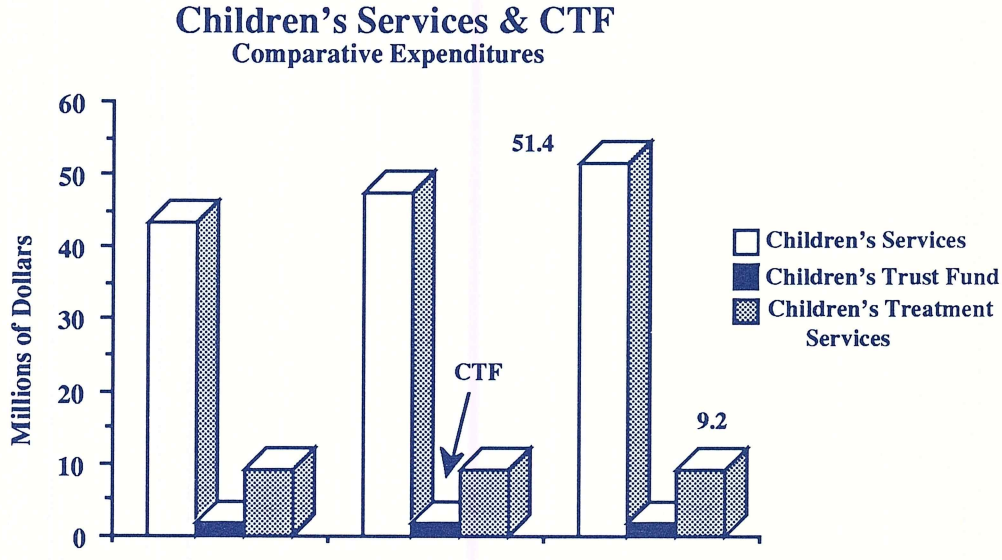


Figure 6a

2. Current Prevention Efforts in Missouri Are Too Sparse

The Child Abuse and Neglect Law, enacted in 1975 by the General Assembly, mandates the Division of Family Services' involvement in child abuse and neglect prevention. To date, the division's efforts have been focused on public awareness and education, but in a very limited manner: an annual statewide conference; the Parental Stress Helpline; and the efforts to publicize the latter via pamphlets, stickers and cards.

Most of Missouri's prevention programs that exist in the private and public sectors are those funded by the Children's Trust Fund (CTF). Established by statute in 1983, CTF provides money to develop community-based child abuse and neglect prevention efforts. CTF is funded primarily by individual and corporate contributions via the state income tax checkoff system; CTF does not receive annual appropriations from the state's General Revenue. Thus, CTF encourages innovative community-based activities to protect children and strengthen families.

A worthwhile beginning for a much-needed effort, CTF is drastically inadequately funded. Figure 6 illustrates how CTF expenditures virtually disappear when compared to the funds spent on treatment. This commission's number one priority is to have DFS increase their efforts and dollars for child abuse and neglect prevention.

C. Getting Services to Families: Gaps in the Continuum of Care

1. Entry Via the Child Abuse & Neglect Hotline

The Child Abuse & Neglect Hotline — a 24-hour-a-day, seven-day-a-week service — has been in operation since 1975. Its purpose is to identify children at risk for abuse or neglect. DFS is mandated to investigate all calls to the hotline. Persons calling the hotline may be either professionals mandated by law to report suspected cases of child abuse or neglect

(health care professionals, teachers, social workers, child care providers), or others (friends, neighbors, relatives).

In the 12 years of the hotline's existence, the number of reports has increased dramatically: from fewer than 10,000 in 1975 to almost 45,000 in 1986, as shown in Figure 4. Most of the upsurge in reports occurred from the late 1970's to the early 1980's, when the issue of child abuse and neglect received a great deal of public attention.

Most recently, the number of reports seems to be leveling off, as indicated in Figure 4. About 40 to 45 percent of total reports are verified by DFS investigation. About two-thirds of these verified reports involve some type of neglect; the remainder involve physical and/or sexual abuse.

In substantiated cases, DFS will open a protective services case. The children's services worker will work with the family to develop a treatment plan intended to remedy the conditions that led to the abuse or neglect.

Problems Snarling the Hotline's Usefulness

Several key areas regarding the hotline have been targeted for improvement by this commission. These include:

- the use of uniform criteria on a statewide basis that clearly define child abuse and neglect;
- the need for DFS to use clear guidelines to document investigative findings. This will determine if abuse or neglect has been verified or is likely to occur, and whether children are at risk in a particular family situation;
- the determination if DFS should open a protective service case or a safekeeping case (safekeeping, as described earlier in this report, is the category into which families at risk are placed when the family itself requests assistance). However, 16 percent of DFS cases are classified as "other," i.e. outside either protective services or safekeeping;
- the initial investigation period is often a time of crisis for families and, unfortunately, also a period when services are not generally provided to families. The time elapsed between the investigation and the referral to treatment services for non-emergency cases can extend for weeks. This serves to deter, frustrate and confuse families;
- the disparity between verified cases of child abuse or neglect when considering mandated reporters as compared to anonymous persons making reports. The rate of substantiated reports from mandated reporters is declining, while the rate from anonymous reporters is increasing. These diverging trends perhaps suggest that mandated reporters are not fully informed of those indicators constituting abuse or neglect;
- the investigative process often produces negative effects on a family because parents are fearful of the stigma of child abuse and fearful of having their children removed from their home. Yet parents have no mechanism to file a complaint or ask for a review of their case by DFS, nor are they fully informed of their rights and the avenues of filing a grievance. Their only recourse is through the circuit court, a system that is frequently time-consuming and complicated; and
- the DFS staff who investigate or treat suspected cases of child abuse or neglect often are insufficiently trained (currently, before a social worker may take over management of a case, each is supposed to complete 96 hours of education and training specified by DFS. In addition, 32 more hours are supposed to be completed before 12 months' employment elapses). Every year

thereafter this commission recommends that each social worker and supervisor should undergo at least 32 hours of training. Furthermore, there are inadequate appropriations for staff to both conduct investigations and provide services.

2. Serving Abused and Neglected Children

Currently, DFS serves about 60,000 children annually. Approximately 75 percent receive protective services while still in the family home. The remainder are placed outside the family home in foster care, the home of a relative, group homes, residential treatment facilities, or adoptions. About one percent are in "aftercare," which supervises the child returned to the family home after placement outside. Among the more than 5,000 children in DFS custody, two-thirds were placed there because of child abuse or neglect.

DFS helps abused and neglected children through services provided by its staff of approximately 1,200 children's service caseworkers and through services that are purchased from private providers across the state. DFS caseworkers cite impediments to their helping children and families. These include excessive caseload sizes, insufficient training, and lack of resources.

The amount of funds available to the caseworkers to purchase services that DFS cannot provide fluctuates widely. In the past, there have been periods of surplus alternating with "freezes" on purchase of service via Children's Treatment Services (CTS). As discussed later, these and other factors result in low staff morale and discourage the development of expertise in the private sector.

In 1985, Missouri laws were changed to state that every child was entitled to a permanent and stable home. This entitlement of permanency and stability, however, is not guaranteed to every child who comes under the care of DFS. There is no guarantee that abused or neglected children will receive services to remedy the effect of such maltreatment, nor that their families will receive services that will help prevent further mistreatment. Thus, the die is cast toward breakup of the natural family and placement of children into foster care.

However, placing a child in foster care does not guarantee that these new living arrangements will meet the child's needs any better. Indeed, some children and their natural families will never receive the appropriate services to promote reunification or ensure the child's placement into a permanent home with a new family.

Sometimes, young clients tend to stagnate within the system rather than progress through and out of it. Part of this stems from evaluations or treatment plans that are inadequate or never formulated. This causes children to languish within the system, retarding their social and emotional development. If the child must be removed from the home because a crisis has developed that endangers his or her welfare, then the removal becomes the priority. Matching the child's other needs becomes secondary or is ignored completely.

CTS are available to children and families receiving protective services from DFS, usually because of substantiated child abuse or neglect. Unfortunately, not all services (listed in the appendix) are available in every part of the state. However, DFS attempts to develop resources in regions where service gaps have been identified.

CTS are provided through contracts with community public and private agencies. These vendors contract to provide the specific services that are listed in the appendix of this report.

Over the years, such services have been designated by names such as home-based services, child abuse and neglect treatment services, multidisciplinary services and contractual treatment services. The specific name reflected the budget appropriation from which

the funds were paid.

Beginning in Fiscal Year 1985 (FY85), all of these programs were consolidated into one appropriation and renamed Children's Treatment Services. Table 1 shows expenditures for treatment services purchased from vendors for a five-year period (for years prior to FY85, expenditures for programs roughly equivalent to current CTS are included).

of prevention or treatment as noted in Figure 6b. The CTS expenditures for treatment only have been relatively meager while the ratio of the number of children needing treatment to the number of DFS staff has increased annually. In 1987, approximately $6.7 million went for CTS treatment while $27.5 million were spent on foster and residential care. This is a dangerous trend towards funding the removal of children from their homes rather

Table 1

Children's Treatment Services

Year	Total Expenditures	Protective Services Day Care	Average Number of Clients Served Per Month
FY-82	$ 786,650	Not Available	Not Available
FY-83	1,350,538	$ 712,940	Not Available
FY-84	1,838,881	1,551,297	Not Available
FY-85	3,025,831	2,665,213	3,947*
FY-86	4,966,230	2,373,960	5,524*
FY-87 (projected)	5,400,000	2,780,000	5,900*

*** The number of clients is a duplicated count; clients who receive more than one type of service or who receive services from more than one type of service or who receive services from more than one provider during the month will be counted by each provider. Data comparable to FY-85 and FY-86 is not available to earlier years.**

Note, however, that not all CTS funds go for traditional treatment services such as counseling or family therapy. Instead, a large portion of these funds are used to purchase "protective service" day care. Thus, the CTS expenditures provide less of an incentive than expected for the development of either a larger quantity or greater expertise in child abuse treatment in the private social service community.

In recent years, the funding of foster and residential care, known as "back end treatments", has increased much more than funding

than funding preventive and treatment services that strengthen families and keep them intact.

3. Children Caught in the Web

Once children enter the system, its breakdowns often prevent truly effective services from being rendered. This commission finds three general areas where the system as currently designed fails to move children through and out. These are:

- inconsistent evaluations — a child's point of entry into the system is inconsistent from DFS to the Depart-

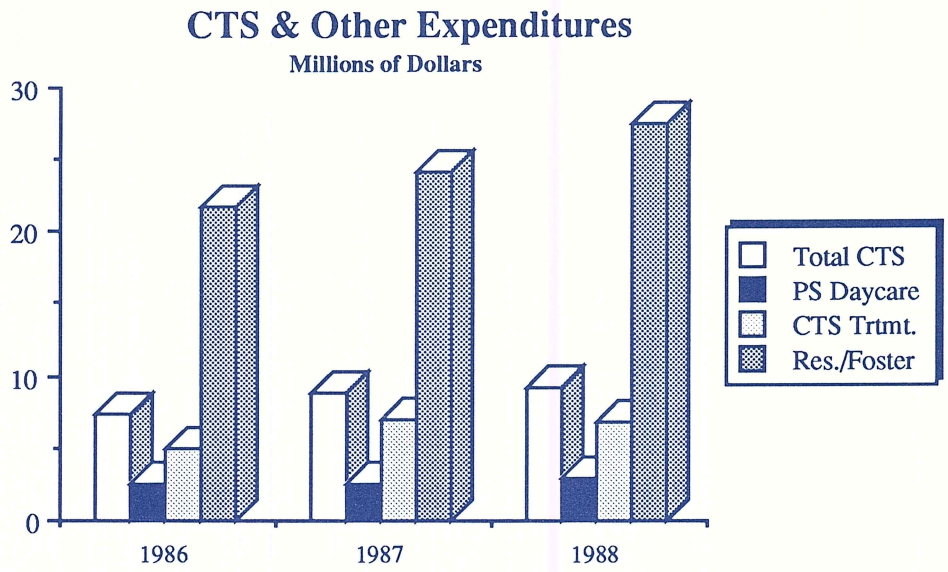


Figure 6b

ment of Mental Health (DMH) to the Division of Youth Services because of the lack of comprehensive standardized evaluation procedures;

- lack of a comprehensive treatment plan — a child's course through treatment is altered many times without an end point being achieved (or even planned); and
- failure to monitor progress — a child may remain in a placement that is no longer appropriate, based on his needs. Conversely, a child may be forced to move before he or she is ready because his or her foster parents may be unable to provide the type of care the child needs.

Inconsistent Evaluation Methods and Procedures

This problem results from lack of coordination within an agency or between agencies. This would be prevented by the development of standardized evaluation methods and tools that provide a comprehensive assessment of a child's needs, from the outset, for all children entering the DFS system. With consistent evaluation procedures, a child's movement through the system (and out) would be facilitated.

Standardized assessment tools are also critical for the staff. Such information formats ensure that information relevant to all child care professionals is obtained initially and throughout the child's course of treatment.

Lack of Comprehensive Treatment Plan

Children placed outside their natural home need a comprehensive treatment plan that serves as a road map. This plan would chart a child's course of treatment, identify time periods at various treatment crossroads, and convey some intended philosophical direction to subsequent treatment providers. Thus, regardless of the number of professionals involved in the child's treatment, all would have the same focus for treatment.

Meanwhile, the treatment plan needs to be modified and evolve as the child progresses (or fails to progress) to various treatment plateaus or crossroads. Older children also need an opportunity to influence their own treatment regimens, subject to factors like maturity, disposition and progress. Likewise, the professionals who guide and counsel the child should have the latitude necessary to

alter the child's course based on the child's needs and progress.

Thus, the plan is not etched in stone. Its intended course should not be altered arbitrarily or because state funds dwindle. Rather it should evolve as the child's needs change, with reconsideration at periodic intervals providing a safety net to ensure that no child is ignored. The plan should be based on the child's current needs but have the flexibility to respond to the child's progress or regression.

Lack of Progressive Care Because of Inadequate Monitoring of a Child's Progress

Even with a proper evaluation for entry into the system, and after a treatment plan is established, children can still stagnate within the system. A child's care must conform to the prescribed plan, but the care can deviate if the rationale is documented. To alter the course of a child's treatment or placement because DFS fails to assess, monitor or analyze the child is unacceptable.

Acceptable modifications to the treatment plan are based on a child's progress (or lack of progress), the availability of more appropriate resources to accommodate the treatment plan, and "informed choice" changes as requested by the child. Failure to monitor the child's progress, failure to move the child along in the plan, and failure to establish congruence between the treatment prescribed and what actually happens to the child are all unacceptable. These failures are those of a child's professionals, not failures of the child or the system.

One reason for these failures are inconsistent or changing guidelines communicated between DFS staff at local and central offices. Furthermore, DFS is often viewed as inaccessible by outside groups such as contractors, the juvenile courts and the public at large.

Twenty-five percent of the DFS caseload is for children in care outside the natural home, so-called "alternative care." At its worst, the system lacks respect for a child's needs, a child's perspective and a child's future. However, this criticism does not imply that DFS staff are not professionals or do not possess well-meaning skills. On the contrary, the very nature of this process depletes emotional energy from the staff, especially considering the large and complex caseloads. Furthermore, decisions about a child's future are typically made without consulting the child, fostering insensitivity to the child's ethnic background and religious upbringing. The system force-fits children into available out-of-home placements instead of customizing placements and treatment plans to fit the child.

Kevin

Kevin was four years old when his doctor, a pediatric neurologist, first met him. Kevin was mildly hyperactive and epileptic, but these conditions were kept under control by treatment. Kevin had a bigger problem than his medical needs, however. His mother's boyfriend didn't want to help care for the child, so he issued an ultimatum: Kevin's mother had to choose between Kevin and her boyfriend. She chose her boyfriend. Eventually, her parental rights were terminated.

Kevin became a ward of the state of Missouri and entered the world of DFS. Since DFS did not have the financial resources to provide for Kevin's care, he was shuttled between a succession of foster homes and residential placements. At one of these, Kevin was the only ambulatory patient. Eventually, Kevin was assigned to the DMH, which could provide for his medical care. He accumulated a total of 17 social workers from both departments. There was no continuity of care at any level, except for the doctor who treated him. Placing Kevin in a foster home became impossible, so eventually he was relegated to a hospital over 100 miles from his hometown.

This molding of children like Kevin into available slots occurs because of the gaps in

the continuum of care. Such gaps exist not because of malevolence but of the dearth of placement opportunities and the lack of customized care plans that monitor children's progress through and out of the system.

Currently, even though a child's progress through the system is monitored, there are inadequate resources to provide treatment. The child enters a fixed path, and sometimes stops on that path, without further evaluation and modification of the initial plan.

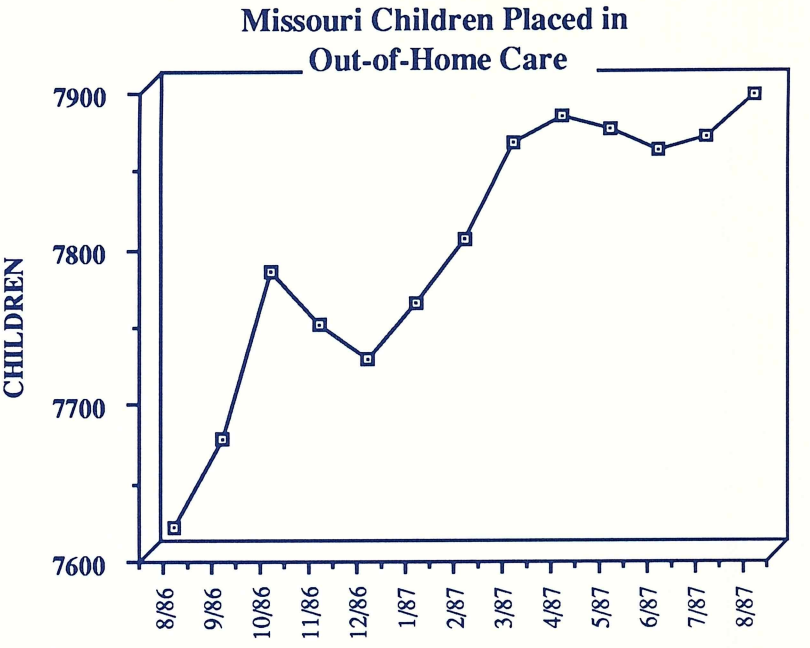


Figure 8

Lack of Permanency Planning

Missouri spearheaded the training of juvenile court judges in planning for children's permanent placement in the most appropriate out-of-home setting. Juvenile court officers and judges should receive 32 hours of education and training each year that addresses the needs of children and families.

When a child is placed in the custody of DFS, a team consisting of a juvenile officer, a DFS employee and other members is mandated by state law to develop a long-range permanent plan for that child's treatment. The plan is to contain several components, including: the type of placement that will serve the child's best interests and special needs, to be provided in the least restrictive setting; and

Table 2

Length of Stay in Foster Care

Child's Length of Stay in Foster Care (months)	Age of Child (Years) 0-2	3-5	6-8	9-11	12-14	15-17	18 & over
0-3	181 (23%)	122 (15%)	88 (11%)	77 (10%)	165 (21%)	163 (20%)	1
4-6	143 (28%)	64 (12%)	65 (13%)	61 (12%)	96 (19%)	78 (15%)	3 (1%)
7-9	128 (28%)	68 (15%)	52 (11%)	56 (12%)	76 (16%)	84 (18%)	2
10-12	110 (25%)	86 (19%)	57 (13%)	47 (11%)	60 (14%)	82 (18%)	2
13-15	90 (24%)	59 (16%)	49 (13%)	41 (11%)	45 (12%)	85 (23%)	4 (1%)
16-18	69 (21%)	56 (17%)	50 (15%)	33 (10%)	61 (19%)	57 (17%)	3 (1%)
19-21	64 (21%)	62 (20%)	48 (16%)	29 (10%)	33 (11%)	61 (20%)	6 (2%)
22-24	50 (17%)	60 (21%)	42 (14%)	37 (13%)	49 (17%)	48 (17%)	3 (1%)
Over 24	88 (5%)	447 (27%)	334 (20%)	221 (13%)	238 (14%)	259 (16%)	69 (4%)
	923 (18%)	1,024 (20%)	785 (15%)	592 (11%)	823 (16%)	917 (18%)	93 (2%)

Total: 5,157

appropriate services for the child and his family to facilitate reunification.

Permanency planning — mandated by state law — is the ideal. However, this valuable idea is failing to thrive in Missouri. Children are not being cared for in appropriate out-of-home settings. As of August 31, 1987, over 140 children in DFS custody under the age of three have been in foster care for more than half their lives — 19 months or longer. Over 300 children three to five years of age have been in foster care for longer than two years. Table 2 lists children's stay in foster care by age. The total number of children in out-of-home care during a one-year period (August 1986 to 1987) is depicted in Figure 7. Unfortunately, when the system breaks down, DFS is not meeting state policy on finding permanent homes for children.

Two brothers, 10 and 12 years old respectively, had their case reviewed by a Jackson County judge. They had been in foster care for about nine years. The children's parents had no contact with them in over seven years. Testimony presented at the hearing indicated that the only impediment to adoption was the boys' ages. But this impediment was created by DFS itself, which had allowed the children to remain in foster care for nine years.

Fifteen percent of all Missouri foster children with a goal of "return home" have remained in foster care longer than two years. Some children continue in foster care for six, eight, ten years or more. According to a report published in 1986, one-third of children in foster care move twice or more during a six-month period. For any child, adjusting to change can provoke anxiety. For a foster child, frequent moves reinforce the feelings of rejection that erode self-esteem.

At any given time, over 5,300 children are in the custody of DFS. Another 550 children are in court-ordered DFS supervision, mostly in the care of relatives. Many of these foster families would undoubtedly be willing to adopt these children if given the chance. But until DFS and the juvenile courts take steps to legally end parental rights, these children remain in perpetual limbo, never really belonging to any family. For some children, the trauma becomes too much. They begin to rebel against the foster family that has nurtured them. Some become anti-social, commit crimes, or develop life-long habits of drug abuse. Some never get treatment for earlier abuse or neglect. The need for intimacy, then, when frustrated long enough, exacts a terrible price.

Foster care families who are strangers to a child provide a better environment than most institutions such as group homes. Foster care family placements are less expensive, but the state does not provide the types of incentives that would facilitate foster families' recruitment, reimbursement and retention. This commission concedes that safeguards in reimbursement ensure that individuals and groups do not take advantage of the system. We also believe that the system needs to provide incentives for relatives to act as foster families and for new foster families to be brought into the system.

When a child must be removed from the parental home, relatives are often willing to act as foster parents, particularly on a temporary basis. Yet the state offers no compensation to a child's relatives for room and board. This discourages well-meaning but financially strapped relatives from stepping into a role that carries great potential benefits for the child. Thus, a child must be placed in a foster family of strangers who are paid per diem rates.

Placement Mismatch/Lack of Resources

There is a lack of equal access to benefits for children of this state. This lack of resources translates into frequent placement mismatches. That is, children are placed in an available slot simply because it is open, not because it is the best placement for those children.

Ricky

In June 1983, seven-year-old Ricky came to the attention of DFS when the division received a report that he was being abused. After the third such report in late 1984, Ricky's parents were arrested and the child was placed in DFS custody. By then, Ricky's behavior — extreme aggressiveness, poor control of his impulses, and occasional complete withdrawal — caused him to undergo the first of several psychiatric hospitalizations. Ricky's parents worked with DFS to undergo individual and family therapy, and he was returned to their custody in June 1986.

Four months later, Ricky's father brought him to the local DFS office and surrendered custody, explaining that neither he nor his wife were able to control the child's behavior. Once again in DFS custody, Ricky was re-hospitalized.

Because of Ricky's impaired intellect (moderate mental retardation) and epilepsy that requires medication, he is adjudged by DMH to need a two-parent foster home or small group setting, not hospitalization. Yet none of the facilities that currently provide contractual services to the state are willing to accept a child like Ricky who has such special needs and is so potentially disruptive. He remains hospitalized.

Thus, children like Ricky and Kevin (whose cases were described earlier) are force-fit into available placement slots. Not only do these placements not meet the needs of the children, they frequently entail institutional care that is by its very nature the most costly of all out-of-home placements.

Residential Care

The plight of foster families, guardians, and other child care providers deserves thoughtful analysis. In Greene County, for example, there is a dearth of appropriate residential treatment. When there is no space available, children must either be moved out of the county into a larger metropolitan area where they can be housed, or be placed in settings where they receive inappropriate care. In either case, the family does not receive counseling, nor do the odds favor family reunification.

Commonly, the state refers children to residential treatment centers but state budget limits payment for their care. Often, the state refers children to inappropriate facilities.

As of October 30, 1987, 296 children are on the waiting list maintained by DFS for placement in residential care. By level of severity, the waiting list composition is: Level I (mild) — 53 children; Level II (moderate) — 108; Level III (severe) — 135. Of the 296 on the waiting list, 64 children are awaiting placement in a group home before being transferred to another facility.

As of November 1, 1987, 716 children reside in Missouri's group homes. The numbers of children in residential treatment have doubled in the past four years.

Lack of Inter-Agency Coordination

The juvenile court in Greene County recently placed a boy at the Springfield Children's Home but was limited by statute to pay only $8 a day for this child's care. The juvenile officer had recommended that the boy be placed in another residential treatment facility at a rate of $66 per day but needed a place to house the boy until a space occurred in the other facility. Thus, the juvenile court wanted the home to agree to care for this boy for two months for only $8 a day. Because of the boy's aggressive behavior, the home had to place him in a severe needs, intensive treatment unit where costs exceed $70 per day per child.

The state exacerbates the desperate financial plight of facilities such as these that are already strapped for funds and are not being subsidized by the state. The state does not

Table 3

Daily Reimbursement Rates for Day Care

Age of Child in Years	Children in Foster Care*	Children in Their Home**
0-2	$9.25	$8.15
Over 2	$8.74	$7.15

*These children have been placed in DFS protection.

** These children have families who are receiving some type of welfare subsidy, such as Aid to Families with Dependent Children (AFDC).

furnish capital funds to allow crowded facilities to expand the number of children for whom they can care. Instead, the state places children inappropriately in hospitals, where they pay $300 or more per day plus physician costs. Consequently, children are being warehoused in inappropriate facilities where the cost of care is excessive. Overcrowded child care facilities are not offered any incentives or start-up capital to increase the number of children they can house.

Inadequate Day Care

Day care payments for children still in the family home and for children in foster care are also inequitable. As listed in Table 3, the state has established fixed rates of payment for day care based on the child's age and the family's economic status. The state pays $8.75 to $9.25 per day for a foster child to be in day care while the foster parent works. In a town the size of Columbia, quality infant day care costs $16 to $19 per day; for preschoolers, $10 to $13 per day. St. Louis or Kansas City figures are substantially higher. Clearly, the reimbursement schedule is inadequate.

State policy forbids foster parents from making up the difference. Even if a foster family could afford to make up the difference from its own pocket, this policy and fixed low rate of payment explain why some day care providers refuse to accept foster children.

In summary, a continuum of care becomes an impossibility when there exist problems such as:

- inconsistent evaluation methods and procedures and lack of a comprehensive treatment plan;
- lack of progressive care because of inadequate monitoring of a child's progress;
- inadequate inter-agency coordination;
- insensitivity to the child's perspective or wishes;
- gaps in placement options;
- the legal limbo miring children so that they cannot be released from parents, making them available for adoption; and
- lack of equal access to benefits because of a family's geographic or economic status.

4. There Is No Continuum of Care

Currently, there is no plan to provide a continuum of care. Fragmentation of care results from a lack of inter-agency coordination, lack of resources and concomitant lack of cost effectiveness. Children in need of services who have not been abused or neglected often never enter the system, children such as Fred and his family.

Fred

Fred was quite immature for a typical 15-year-old. He was one of five children who lived with his mother and grandmother. The latter clearly ran things at Fred's house and was the only reliable breadwinner in the family, having worked for several years as mail supervisor at a hospital. By contrast, Fred's mother changed jobs frequently. Nevertheless, their pooled incomes were prohibitively high so that Fred was ineligible for social services that would include free counseling (ironically, had Fred entered the juvenile justice system, such help would have been provided).

Fortunately, Fred's public school system provided some help for his learning disability. However had he improved his academic performance, he would have to attend a different school, away from his friends. Thus, instead of receiving help and encouragement, Fred was not given any incentive to help himself.

Fred isn't the only one in his family who needs help. His mother displays evidence of lack of maturity and poor parental skills. For example, Fred wants to know all he can about his father, but his mother offers no information. She says that she wants Fred to "grow up," yet she rewards his childish behavior with affection. Fred needs self-confidence and a nurturing environment. Instead, his immaturity is encouraged.

5. Problems Faced by Foster Families

Even though all foster families are supposed to receive training while serving as foster parents, many do not. In "A View from the Other Side," a DFS foster parent survey published in July 1987, some problem areas identified by survey participants were:

- inadequate compensation by the state for foster children's room and board;
- difficulty of foster parents in metropolitan areas in obtaining reimbursement for medical expenses outside Medicaid. Often, foster parents could not even find a physician who would accept Medicaid;
- dealing with their foster child's parents or other relatives;
- difficulty in contacting DFS staff outside normal working hours, a problem for many metropolitan foster parents;
- lack of information about the child at the time of placement;
- lack of awareness of DFS policies; and
- need for training in specific areas, such as helping their foster children who had been physically abused or who had disabilities such as learning problems.

6. Management Problems Hampering DFS Effectiveness

The Department of Social Services Should Conduct Long Range Planning

A major problem in providing adequate care for abused or neglected children, then, is the lack of places for these children to live when they must be removed from the family home. Creating customized placements entails financial costs that may seem high. Yet they are cheaper than the long-range costs that result from inappropriate institutional placement (such as in a psychiatric hospital). Customized placement is also cheaper in the long run than allowing these children to become non-productive adults who continue the cycle into the next generation.

To bring such a continuum of care into fruition, a long-range planning perspective must permeate state agencies. Their planning should go beyond a specific program or service and have a horizon extending beyond a month or quarter or fiscal year.

The appropriations for children's services indicate trends in funding of programs for abuse and neglect victims. The largest increases in expenditures have been for out-of-home placements (see Table 4). Although the

Table 4

EXPENDITURES BY CATEGORY
1982-1988

Child Abuse/Neglect	$1,087,967	$1,312,375	$1,082,375		$362,000	$362,000	$328,000
Foster Child ACC							2,000,000
Foster Care	7,255,095	11,477,111	11,787,111	9,674.512	8,531,237	9,272,690	9,293,000
Day Care	6,400,000	11,128,152	7,779,839	7,146,888	9,000,000	8,392,690	10,671,571
Res. Treatment	7,000,000	6,828,000	6,828,000	9,256,975	13,275,724	14,150,942	18,425,100
Ther. Group Home						400,000	673,000
Adoption				1,785,143	3,230,699	4,550,934	5,030,000
School Dist. Pay							336,000
POS	22,707,441	13,350,123	1,285,000				
CTS-HB, DCTS, ISP		1,000,000	800,000	5,900,000	8,902,000	8,902,000	12,170,008
Staff Training	1,000,000	386,904	222,723	200,000	200,000	200,000	200,000
TOTALS	$45,450,503	$45,482,665	$29,785,048	$33,963,518	$43,501,660	$46,231,256	$59,126,679

annual appropriations are difficult to track because the funding categories have been relabeled over the years, the amounts spent on foster care and residential placement have increased dramatically. On the other hand, the funding of prevention and the funding of treatment delivered while the child is still in the home has remained much lower. There have been little or no DFS expenditures for primary and secondary prevention. As previously noted, the CTS expenditures for treatment are less than they appear to be because protective service day care is included in this category. Thus, the total day care expenditures, while still insufficient, are more than what appears in the day care category.

A long range planning perspective would develop new programs and activities to coordinate with those of other public and private agencies at all levels — local, state, regional and national. Priorities would take into account numbers of clients, costs and alternatives. Such a long-range perspective and broad-based participation in the process would enhance its outcome because of the sense of stewardship that built the effort. Furthermore, such a perspective would provide fodder for private agencies and groups to develop needed programs and services.

Long range planning requires a broad, solid foundation of knowledge. Agency staff must know the numbers of programs and clients they currently serve, and the goals they hope to reach. Since DFS cannot be all things to all people, it must establish a few key principles that are flexible, durable and fairly concise. These principles would constitute its mission statement. All employees would understand this statement and have the knowledge, resources, education and supervisory support to implement it.

In order for this to occur, clear lines of authority must be established with good communication, both within and between agencies. Here is where the system usually breaks down, especially if a family is affected by more than one program, agency or office. The undesirable outcome are clients who are either dissatisfied or, worse, further harmed emotionally or physically.

Staff Turnover

DFS has experienced significant problems in its frequent turnover of staff at all levels,

Missouri DSS/Division of Family Services
Area Offices

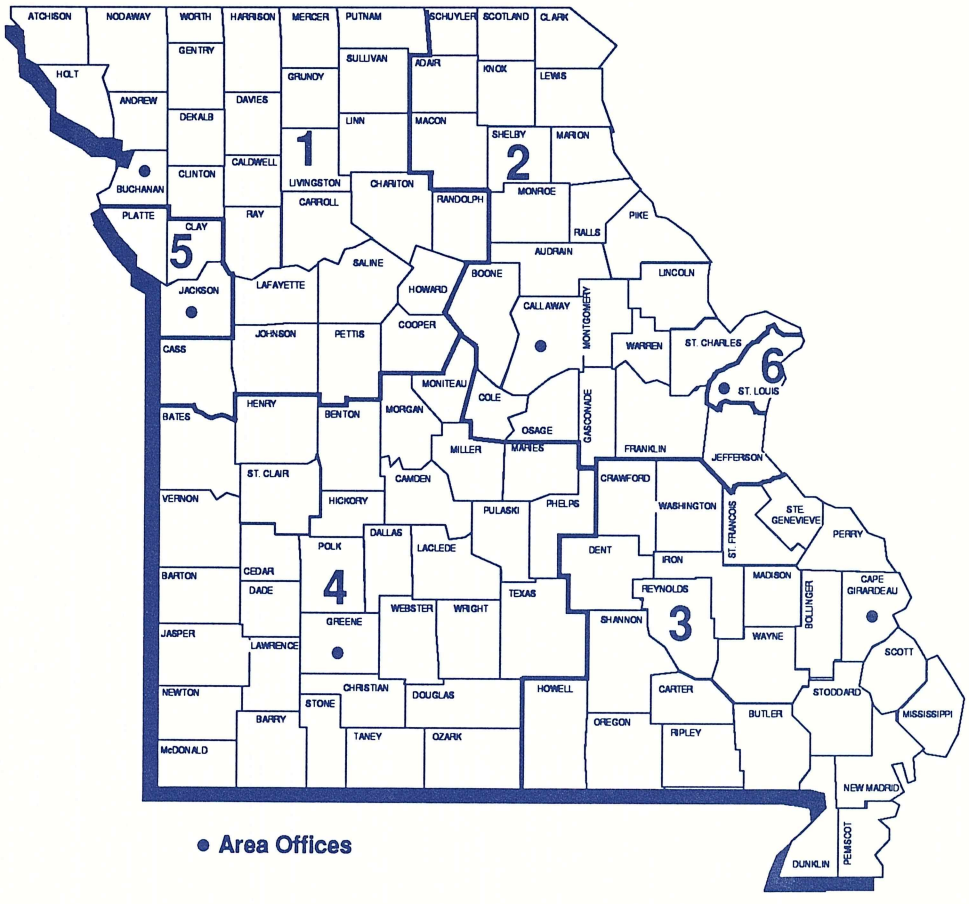


Figure 9

Table 5

Turnover Rates Among State Social Service Workers
September 1987

DFS Area	Number of Workers Allocated	Number of Workers Who Left	Percentage
1	110	5	4.5
2	177	21	11.9
3	127	15	11.8
4	209	26	12.4
5	178	35	19.7
6	306	33	10.8

especially social service workers, as shown in Table 5. In addition, the average tenure of the DFS director has been one year. One result of this frequent turnover, especially in the chief administrative position, is that there is no long-range planning or vision for the agency.

Many issues continue to plague the agency: its philosophy for services, and its self-identity — are children's services workers to be treatment providers or primary case managers? Without clarity in its staff job descriptions and the concomitant effect on client services, DFS falls short in many areas. Staff morale dips as frustration, overwhelming feelings and discouragement build.

Consequently, the community perceives that DFS staff are unable to do the job. Although qualifications need to be upgraded, along with training requirements, DFS staff need to be given doable jobs providing manageable caseloads and the resources to do the job. This commission's opinion, bolstered by reports from social workers and their supervisors across the state, indicates that many social workers' tasks could be performed by aides, transportation specialists, etc. Due to excessive demands on staff time for such tasks and for filling out reports, a recent study found that social workers spend only 25 percent of their time in direct client contact.

Current personnel policies also impede staff ability to respond to client needs. Fixed hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, are not when families are available or when families are in crisis. DFS staff need flexible time schedules to include evening and weekend hours, to permit better services to the families it attempts to serve.

Poor DFS Image

The image of DFS has become one of "service to the poor." Thus, persons who are not poor or receiving subsidies hesitate to approach the department for programs such as those on parental skills, from which they might benefit. DFS should make sure that its social workers refer clients to classes on parental skills. The need for parental skills, particularly for teenage parents, single parents and others, cannot be overemphasized. Thus, the department needs to create an image of "service to all citizens."

Evolution of department policy and improvement of its image will take time and require a great deal of effort. Such a turnaround requires more than just legislative change. It requires real leadership from politicians and private citizens who will act as advocates for reform. Such efforts will result in better service to clients. They will also help shore up the sagging morale among DFS employees, who are drained mentally, physically and emotionally by the current system. This constant drain on staff contributes to tardiness, absenteeism and eventual employee loss due to burnout, as shown in Table 4. This downward spiral snares the client, since there is discontinuity in whatever services are provided.

In summary, Missouri needs to boost the management incentives under which DFS offices operate so that all families can be served and will be better served. This commission finds that DFS fails to:

- undertake long-range planning;
- establish clear lines of communication and authority within and between agencies, including those in the private sector;
- provide adequate staff development and training;
- set caseload size standards according to the individual cases' degree of difficulty;
- improve the public image of DFS;
- train parents in parental skills;
- institute customized placements for children; and
- investigate the causes of high DFS employee turnover in some counties or state regions.

Inconsistent Rate Structure

The problem of children being warehoused is further compounded by the fact that each division within the department sets their own rates for contract service providers. Furthermore, rates and benefits vary from department to department. Thus, departmental management has not refined their rate structure nor set a consistent basis for rates. If a rational, universal rate structure existed, more congruence would result. Discrepancies or variations would occur for some more accountable reason than whim. Thus, we advocate the creation of a uniform rate structure.

Such an event would facilitate accounting and act as an incentive to providers to furnish services across-the-board, not just in the more lucrative program or service areas. A more balanced and rational approach to rates and reimbursements would facilitate the greater provision of services and result in a wider array. The current expenditures are shown in Table 4.

Currently, contractors are encouraged to provide low-cost services, not cost-effective (quality) services. Contractors need and deserve equitable reimbursement. However, the state should not reimburse providers merely as a function of their quoted costs (which may be excessive and derived from "creative" accounting), but through a systematic and fair fact-finding exercise that would disclose those costs that are reimbursable.

Thus, cases using interim placements, make it painfully clear that Missouri has a long way to go before fair and equitable reimbursement for group homes will become a reality.

Fiscal Management

Legislative funding practices adversely affect rate structures in several ways. For example, the state currently appropriates funds on an annual basis. While advantageous for accounting, this practice adversely affects planning, discourages contractors and detracts from the consistency of service they provide between budget cycles. This short-range perspective misallots funds: programs must spend all their budgeted funds by the end of a fiscal year or risk losing part of their allocation next year. Other programs are forced to curtail services when they run out of money before the start of the next budget cycle.

The legislature should adopt more flexible budgeting policies to allocate resources for family services. Those programs that have successfully served clients yet maintained a budgetary reserve should be rewarded, not punished. Within DFS, better fiscal management of CTS funds is essential.

Access to Medicaid funds varies within DFS, among divisions within the Department of Social Services (DSS), and between DSS and other departments. Currently, some divisions within the department can enroll their clients in Medicaid, while others cannot. This selectivity in enrollment authority encourages some agencies to "dump" clients into other agencies that have the budgetary resources — but not necessarily the right mix of services and programs, as was described earlier in this report in the case of Kevin. This climate stigmatizes clients on the basis of family income and reinforces the image that only poor clients are served. Thus, equity of services to all clients, regardless of their economic situation, is the underpinning of overall improvement in the department's functioning.

In summary, a variety of situations impedes the establishment of fair and equitable rate structures to reimburse those who provide foster care. Currently, the state has:

- a variety of fee schedules;
- reimbursement rates that do not cover costs;
- misallocated funds due to inflexible fiscal periods;
- improperly placed children because of a shortage of funds;

- encouraged low-cost rather than cost-effective services because of the current bidding process;
- failed to compensate for relatives who act as foster parents;
- failed to provide the incentive to develop new services;
- instituted inadequate incentives to increase the corps of families willing to provide foster care; and
- failed to make Medicaid coverage available to all departments.

D. Missouri's Children and Their Families Cry Out for Family Preservation Services

1. Missouri's Children Are in Dire Need of Services

More than 60,000 abused and neglected children will be in the DFS protective services system in 1987. Currently, 4,200 families with 11,000 children are in protective services in St. Louis City and County. Additionally, approximately 2,100 children are in foster care. Unless things improve, children entering the St. Louis foster care system will remain an average of three years. One out of two foster children will stay more than two years. Generally, they will be transferred to several homes and have numerous social workers.

Services to strengthen families, to remedy the effects of abuse, and to reduce foster placement are not provided to the majority of families. According to a 1985 study of Missouri's services to abused and neglected children, fewer than 20 percent of children and their families were receiving any counseling services (Citizen's for Missouri's Children). As described earlier in this report, foster families often feel inadequately trained to help these children or to deal with the children's relatives. Missouri's system provides too little, too late for abused and neglected children.

This year, Missouri will spend over $25 million for out-of-home placements for children. Less than $9 million will be spent to keep children in their homes. Missouri spends more money to place children in foster care than to treat children in their homes. Without effective services emphasizing early intervention, children's problems become more severe, requiring more costly and extensive services.

The lack of financial resources in Missouri contributes to the placement of children in foster care and the delay in reunifying them with their families.

Missouri law requires that all reasonable efforts be made to prevent the out-of-home placement of children into foster care. For some children, this placement occurs because families do not have adequate housing. Consequently, the court may order that children be removed from their home. Most often families do not have resources to repair the dwelling or move elsewhere.

The state does not have any mechanism to financially aid such families. In several states, lawsuits have required that housing be sought for families on the grounds that such an action is reasonable to prevent out-of-home placement. It is also more humane for the children and families, and more cost-effective than paying foster care costs.

Lack of financial assistance for housing and other immediate needs prevents reunification of families. Often the child cannot be returned home until the family has a place to live, but the family cannot afford a rent deposit or moving costs or utilities.

2. Why does Missouri Need Family Preservation Services?

Since the passage of the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272), Missouri has joined the ranks of other states in working to reform its child welfare system by reducing the number of children in foster care, reducing the length of time children spend in foster care, and seeking permanent homes for foster children through

adoption. Missouri has passed statutes and instituted agency policies and court rules to provide greater scrutiny of children in foster care. However, funding of initiatives has fallen short.

One critical area not satisfactorily addressed over the years is the reduction of placement of children into foster care. Many reasons explain this lack of development of initiatives. One major reason is the child-centered philosophy underpinning all service delivery.

This child-centered focus is understandable because of DFS obligation to safeguard children. Unfortunately, as this philosophy translates into services, the focus is on treating the child. Protective service systems have tended to design and provide services that compensate for parental inadequacies yet support parental dependence on the social services system. Although the family is not excluded from services, the focus is not on strengthening or preserving the family to enable it to care for its children.

DFS must provide a continuum of services aimed at strengthening families so that families can care for their children. This mandate must extend to one of the two goals DFS professes to achieve, i.e. avoiding unnecessary separation of the child from the family and plcaing children in the least restrictive environment.

3. Family Preservation Is Hampered by the Current System of Service Purchasing

Through the years, DFS has increased its use of CTS to purchase services from private agencies and professionals. In 1985, a needs assessment of abused and neglected children and their families found that less than 20 percent of the needs of families were met by this program.

Not much is known about the effectiveness and the use of this purchase of services because it is not systematically monitored by DFS. This program has been plagued by annual budgetary freezes caused by increased demand for services together with lack of forecasting of expenditure rates. These annual freezes confuse DFS staff and the provider community as to when to refer and when services are available. Routinely, DFS imposes a freeze on spending funds for CTS. This usually occurs in the final several months of the fiscal year. However, in 1987, the freeze was imposed during the first quarter. By the end of the fiscal year, seven percent of the allocation was unspent.

CTS funding is a financial roller coaster that has negative impact on families and children along with private service providers. It results in frustration, distrust, confusion and inefficient service delivery. For some families, the process does not allow timely delivery of needed services that could prevent more severe problems later. Families and children may not receive services, depending on the time of year they enter the system. Furthermore, family services may end prematurely because of a lack of funds.

The contract process itself is complex and does not ensure quality of services purchased. Cost effectiveness, rather than only costs, should be a major criterion by which contracts are evaluated.

4. How Lack of Family Preservation Hurts Children

Many homes are broken apart needlessly. Many children, removed for non-emergency reasons, have languished in an emergency shelter for a year or more. Sometimes, a family is broken apart simply because it is poor.

The Cunninghams

About five years ago, the Cunningham family was travelling through Jackson County in a pickup truck with their five sons. The father went to the local DFS office to try to get money to buy groceries and provide temporary shelter so the family didn't have to live in the truck. While he was applying, authorities located the truck, removed the boys and placed

them in foster care, where they all remained for nearly three years.

When the court ordered that the boys be returned to their family, DFS was still recommending that they all stay in foster care. Three years of foster care for five children probably cost Missouri taxpayers $30,000. Far less money would have been spent to provide emergency temporary housing for the family and to have provided some food and medical care.

Public awareness about the tragic effects of child abuse and neglect is at an all-time high. Laws and policies for reporting and caring for victims have improved. Cost-effective treatment and intervention methods have become accepted practice in many states. Yet in Missouri, too few services are provided to remedy the causes and effects of child abuse. Too many children are removed from their homes because of a lack of services. Foster care, intended as a short-term placement while parents demonstrate their ability to change or while adoptive parents can be found, has become a web in which children are caught.

The problems that create abuse and neglect rarely start with a child — they start with the family itself. No one would argue for leaving a child in a dangerous home situation, but foster care offers no guarantee of a better home. Simply removing the child does not solve the problem; often, it creates more problems. Foster care is too frequently used as a first resort instead of a last resort.

Sally's Kids

Between April 1980 and August 1983, Sally and her three children were reported on 12 occasions to the hotline. Eight of these reports were deemed by DFS to verify the allegations of physical abuse and neglect. Sally genuinely wanted to work with DFS in order to keep her children, knowing full well that they might be taken away from her. However, her continuing problems with parenting and the repeat calls to the hotline set the stage for what was to follow.

In August 1981, the two oldest children became wards of the juvenile court. The court placed them in legal custody of DFS, with the parents maintaining their physical custody. Two years later, all three children were removed from their home and placed in foster care because of continuing evidence of physical neglect and abuse (Sally was receiving counseling but no systematic help with parenting). Sally and her husband visited all the children regularly. However, in August 1985, the juvenile court terminated Sally and her husband's parental rights, and the children were placed for adoption shortly thereafter.

This family was fortunate to have had one protective service worker who sustained the case from January 1981 through October 1983 and acted as an advocate for the parents. While the children were in foster care for two years, they were always placed together and were moved only a few times. Sally and her children were making progress toward a good life despite the lack of concrete help furnished this family. However, the juvenile court judge on the case disregarded DFS petition to remove itself from Sally's case because she and the children were living in a HUD complex the judge disliked.

DFS reports that the judge's decision devastated Sally — she seemed to lose her motivation to maintain her improved level of functioning. Despite further efforts by both Sally and DFS, by summer 1983 Sally and her family were in a crisis: they had left their HUD home, their plans for the new home had fallen through, and there was no money for emergency shelter or food. It was at this point that the children were placed in foster care.

According to Sally's social worker, if Family Preservation Services (FPS) had been available, there is little doubt that this family could have been maintained. FPS would have provided Sally with new parental skills, would have helped her find suitable housing, and

located or purchased emergency food.

Sally and her husband did attempt to work within the system after their children were in foster care in order to reunite the family. However, there were now fewer resources than ever and Sally was ineligible for financial assistance or subsidized housing.

Although the children were eventually placed in a stable, loving, nurturing environment, FPS could very well have made this possible within the natural family. The efforts to maintain this family would probably have been much stronger if DFS philosophy encouraged a method of helping children through a family-centered service delivery.

The costs for foster care for these three children were over $22,000. Their adoption subsidies will eventually cost the state over $81,000. Thus, the state's financial burden for out-of-home placement for these children is over $100,000. Yet the average cost of FPS, as cited by Homebuilders, Inc., is only $2,600 per family. Clearly, FPS is far less expensive. Even more, it keeps natural families intact or reunites them after temporary separations.

Part II

How Can We Help Missouri's Children?

In this report, we outline several measures to accomplish the goal of prevention of child maltreatment to give visibility and accountability for developing prevention programs. Additionally, we believe that a vigorous effort to educate all segments of our society on the means to prevent child abuse would be an effective approach. We also think that parents, children and professionals need access to adequate support services and resources attuned to the goal of prevention of child abuse and neglect.

Currently, Missouri is doing little in the way of prevention. The Children's Trust Fund (CTF) provides money to community groups wishing to help alleviate the problem. There is an annual statewide conference on child abuse and neglect. There is also a state-funded Parental Stress Helpline, and the publication of pamphlets, stickers and cards describing this service. Yet these efforts reach far too few.

A. Institute More and Better Prevention Programs

Prevention programs strengthen the traits of a healthy family that are described in Part III of this report.

1. Prevention Should Begin at the Grassroots Level

Professionals and volunteers alike can work to provide a range of support levels, from low to intense, such as one-on-one efforts. A successful, community-based volunteer program will help parents or other caregivers who participate by:

- developing nurturing friendships between volunteers and program participants whose self-esteem needs the reinforcement that such intimacy provides;
- helping to end caregivers' isolation;
- linking parents with appropriate community programs and services;
- teaching parenting skills and non-violent methods of discipline; and
- modeling effective methods of setting limits (Shaheen, 1985).

However, prevention programs are not free. Even programs using volunteers must be sustained financially. Currently, Missouri spends nearly all funds earmarked for child abuse and neglect on treatment programs, not prevention.

2. Prevention Should Pervade All State Agencies

Besides DFS, other state agencies provide prevention-related services. For example, the Parents as Teachers Program of the Department of Elementary and Secondary Education (DESE), which has won several awards, began in Missouri. This program provides resource materials and guidance to parents to improve learning of preschool age children. Funded at only one third of the need, this program has the potential to be a major force in the effort to improve parenting skills and thus help prevent child abuse or neglect.

The Department of Health sponsors prenatal and perinatal programs that serve a small number of families with known medical risks. For prevention programs to be truly effective, they must be in place and reach the family before abuse or neglect occurs. For many children — especially infants who are vulnerable to the most severe, deadly form of maltreatment — prevention services must be delivered when they are born, or before. Good parenting practices should be taught before the child arrives, through appropriate prenatal and perinatal health services, before bad child-rearing habits become entrenched.

Much can be gained from providers of parenting instruction who are outside the realm of social services providers, such as public health nurses. Most families readily accept advice and directions from health professionals who are regarded as helpers, not as adversaries who might remove a child from the home. Health professionals should be an integral part of an overall prevention strategy because they have access to the family from the earliest moments of the child's life.

The perinatal program, which follows up on high-risk infants after birth, has the potential to identify the earliest signals of impending maltreatment. Yet this program is underdeveloped and underfunded.

The Department of Mental Health (DMH) has prevention programs for drug abuse, including alcohol abuse. While these programs provide important efforts that strengthen families, they lack outreach services to address and reduce specific abusive behaviors before children are hurt. Furthermore, there is no coordination between these programs and child abuse prevention programs.

Thus, Missouri has the ingredients for mounting a truly effective campaign to prevent child abuse and neglect. But there must be sufficient focus, staffing, funding and coordination. Being able to diagnose the problem is of little value if no remedy follows.

3. This Commission Proposes a New Governmental Structure to Prevent Child Maltreatment in Missouri

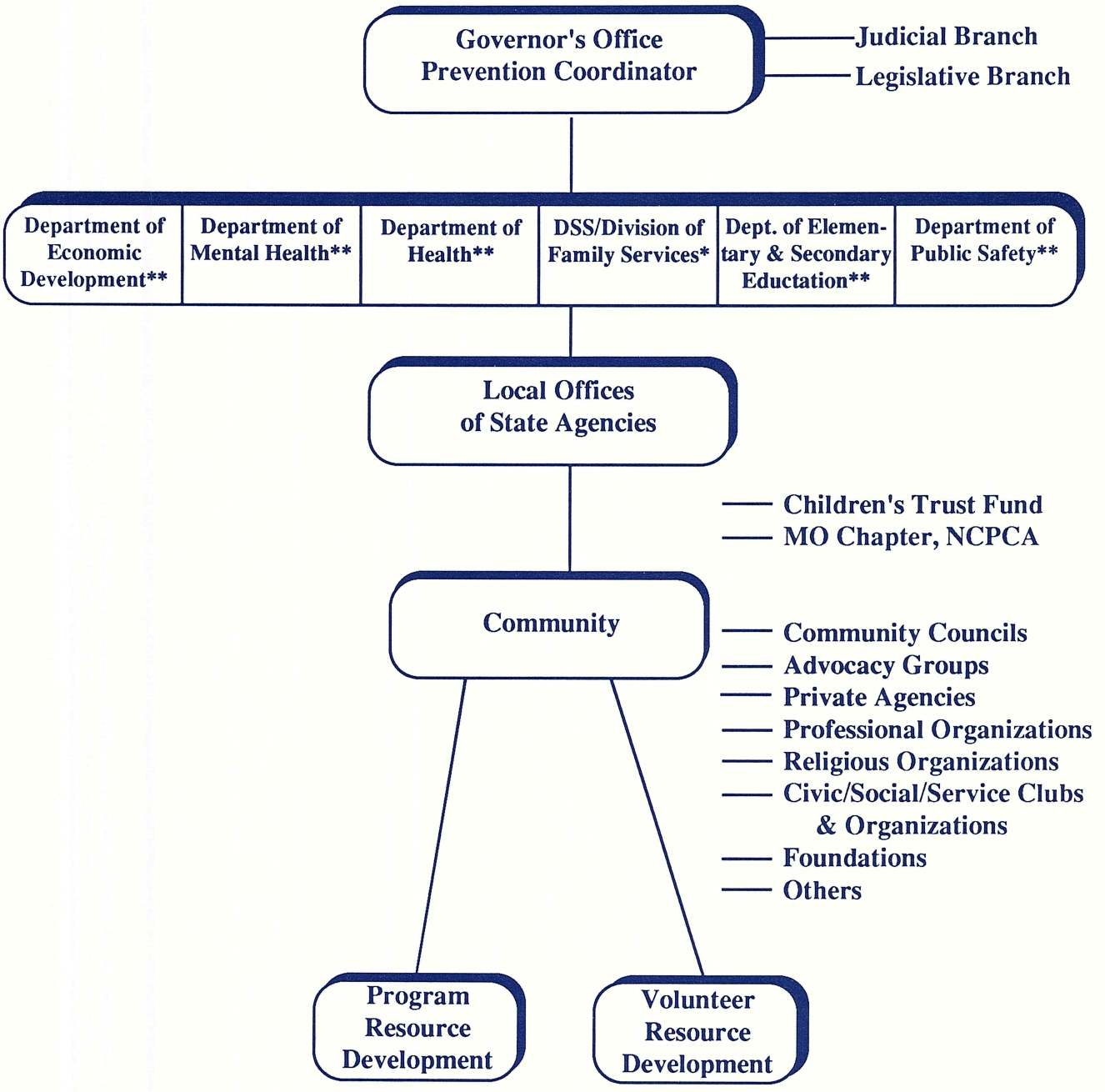
A new organizational structure proposed by this commission, depicted in Figure 8, would coordinate services and provide continuity, endurance and accountability for outcome. It would integrate the efforts of government agencies with those of other public and private groups. Of the recommendations made by this commission, this one received the highest priority.

The basis for implementing this model hinges on the establishment of two key staff positions: a child abuse and neglect prevention coordinator who would work out of the governor's office, and a child abuse and neglect prevention specialist who would be in the Division of Family Services' (DFS) Children's Services section.

The coordinator must be able to reach out from the governor's office to solicit assistance from any agency of state government. Such a highly placed individual would send a clear message that Missouri is serious about prevention of child abuse and neglect (see the appendix for details of job descriptions).

The other state departments identified in the model in Figure 8 should designate staff

Prevention of Child Abuse and Neglect Organizational Model



* staffed by full-time Child Abuse and Neglect Prevention Specialist for prevention implementation

** staff assistance by either part-time or full-time designated staff for child abuse and neglect prevention implementation

Figure 10

persons with positions of visibility, accessibility and authority to serve as in-house prevention specialists. In this way, a coordinated effort can be mounted under the guidance of the coordinator.

If the organizational model depicted in Figure 8 is adopted, realistic goals for successful implementation — with clear lines of responsibility — should be established for review regularly, such as by fiscal year. At least twice a year, progress should be assessed. Once implemented, a program or service should be carefully monitored and evaluated.

4. Multiple Areas for Prevention

Since many events and circumstances contribute to child abuse and neglect, this commission proposes a variety of prevention remedies, centering around education, support, coordination and legislation.

Education

Everyone — parents, children of all ages, professionals, and the public at large — needs to learn positive life skills and practices that, when publicized and absorbed, can prevent child abuse and neglect. This campaign should be carried by all arms of the electronic and print media.

The groundwork for such a campaign will be found in an effective, systematic gathering of data that indicate potentially high-risk pregnancies. That way, specific campaigns directed to a particular region, neighborhood, or cultural group can be developed and later assessed. For example, St. Louis census data indicate that black children are four times more likely than white children to die of infections shortly after birth. This information led to program development to teach women in high-risk census tracts how to take their baby's temperature. They were instructed that when a fever does occur, they should immediately seek medical care for their baby.

Other census data from St. Louis indicate that black children are two to four times as likely as white children to die of accidents or infanticide. In these census tracts, programs need to be designed to assess families at high risk of stress from unemployment, poverty or other conditions in which the likely outcome might be child abuse or neglect. In summary, the establishment of specific data collection systems that measure risks in a particular zip code area, region or neighborhood will enable preventive educational measures to be focused where they are needed most.

Parents are not the only ones who must be educated. But they are certainly an important segment of the population. This commission believes that child abuse does not correlate with a lack of parental love. Rather, child abuse and neglect result when a parent's frustration and despair from lack of basic physical needs, or unmet intimacy needs, explode. Parents can learn effective parenting skills. These can include positive, non-violent disciplinary measures and alternatives to verbal abuse, as well as the basics of healthy children's growth and development. They also need to learn that certain behaviors, such as shaking a child, can produce devastating consequences. Sometimes, homemaking skills or budgeting basics should be the focus; different families need different kinds of help. Communication skills that facilitate interpersonal relationships and enhance self-esteem can also be learned. All Missouri parents need to be aware of the existence of the Parental Stress Helpline (1/800-367-2543).

Life management skills for children of all ages, preschool through elementary, should include training in decision-making, communication, coping skills, self-awareness, self-esteem and values clarification. Health education in the elementary classroom should focus on nutrition, normal growth and development, and the effects of drugs including alcohol. Children should be taught to distinguish between "good" and "bad" touches in order to recognize sexual abuse. Family living skills

and responsible sexual development are also important components.

Older children (junior high through high school) benefit from training in assertiveness and goal setting. They require reinforcement in all those areas outlined above that began in elementary school. In addition, prevention of pregnancy and family living skills are priorities for this age group. When these children live in a family affected by drug abuse, early intervention services need to be provided.

Adolescent parents should receive instruction in homemaking skills, including budgeting, nutrition, child care and family management. This group also needs training in communication, decision-making, self-discipline and several key areas of child rearing such as non-violent discipline methods and normal child growth and development. Peer support groups will help end isolation and enable these young parents to receive empathy from those in similar situations. They should be encouraged to participate in the Parents as Teachers program. Adolescent parents especially need child care in order to return to school, enter job training, or go to work.

Besides the above-mentioned target groups, professionals should receive a wide range of specific educational programs aimed at prevention of child abuse or neglect. For example, professionals should be apprised of the risk factors (and how to detect them) that can lead to abuse or neglect. They need to learn about available programs and services. Professionals also need to network with community resources, including volunteers, as well as with other professionals and community groups. Professional child care providers need to have annual in-service training that emphasizes prevention.

Finally, the public at large needs to learn about what children need, how to select quality child care, and the use of natural helping systems such as churches and other community groups. Everyone should learn to recognize and report child abuse and neglect, using the Missouri Child Abuse & Neglect Hotline (1/800-392-3738) to make any reports. Everyone needs to learn to avoid specific abusive behaviors, such as shaking infants or children. Greater public awareness of the existence of, and purpose of, the CTF would increase its financial base of support.

Support

All segments of society can be targeted for support programs aimed at preventing child abuse and neglect by strengthening the family and helping it to become self-sufficient. Physical support for parents can take the form of employment, housing, food, medical care, or child care. Parents who continue their education or enter job training programs need assistance with child care. Thus, the state or employers should be encouraged to develop and support day care programs and model workplace programs with family-oriented personnel policies. The latter can take the form of flex time, shared time, on- or off-site child care, and paid maternity/paternity leave.

Pregnant adolescents represent a particularly vulnerable group. Not only do they require adequate support to become good parents, their physical needs for shelter represent another crisis.

Nancy

Nancy was raped by a boyfriend and became pregnant. Frightened, she told no one of her situation for several months. Finally forced to confide in her parents, Nancy found them to be understanding and loving. However, the family lived in a small rural community where they felt unable to cope with reaction to this pregnancy. Since Nancy planned to place the child for adoption, she and her parents wanted to keep the pregnancy a secret.

But when the family visited several homes for unwed mothers, they were dismayed to discover that Nancy's new roommates were facing charges of juvenile delinquency or drug

use and were severely restricted: they were not permitted to go home for visits, leave the grounds or even have visitors. Completely discouraged, Nancy and her parents reluctantly decided she would be better off at home.

However, they all still wanted to keep Nancy's pregnancy confidential. Thus, Nancy became a prisoner in her own home. For many months, she was forced to remain indoors and avoid social contacts. Despite her parents' support, Nancy felt extremely isolated. Though she subsequently placed her baby for adoption, Nancy could have benefitted greatly from the opportunity to meet other girls like herself. She and her parents would have been better able to cope with this problem had there been available residential care for girls like Nancy.

Nancy was luckier than most pregnant teenagers, however. Her parents stood by her during the pregnancy, despite the strain. Many pregnant girls are not so fortunate.

Deanna

Deanna came to the Children's Home Society requesting pregnancy counseling and adoption planning for her unborn child. Because she would not consider abortion, her parents would not allow her to remain at home. Deanna spent two weeks sleeping on park benches before arriving at the home.

Like Nancy, Deanna was dismayed to find that most homes for pregnant adolescents were populated by young women who were drug addicts or violent juvenile delinquents. Deanna was sure that she could not deliver a healthy baby when she felt so unsettled and threatened. She began to wonder if her parents were right in insisting that she have an abortion. Eventually, the home was able to place Deanna with one of their former clients who had adopted a child through the home. Although Deanna eventually found safe shelter, she could have benefitted greatly from counseling and opportunities for interaction with other girls like herself available in a group home.

Thus, there are many levels of needs, and all types of supports — physical and psychological — that must be accommodated in a broadly based prevention effort.

Care for school-age children beyond school hours is a pressing need, as are programs that provide care during the summer and on school holidays. The family who requires respite (temporary child care to relieve stress) or occasional child care must also be accommodated.

Sarah

Sarah is an 18-month-old who lives at home with her parents and three siblings. Her developmental delays stem in part from a tracheotomy that requires frequent suctioning. Her desperately tired parents cannot meet Sarah's needs, let alone those of their other three children. This forced neglect adds to the already unbearable tension disrupting this family.

Sarah's entire family would benefit if they were periodically relieved from providing for her constant care. However, Sarah needs one-to-one nursing care. Agencies are unable to accommodate this need because of insufficient funds to cover this expense. Without such relief, Sarah's parents cannot continue to care for her at home. Eventually, institutional care for Sarah would cost the state significantly more than the funds required for immediate respite care to relieve the burden on her overworked parents.

Michael

A related issue is the need for interim care to provide an interface between hospital and home. Two-year-old Michael had a severe medical illness that included a tracheostomy, causing his development to lag. He needed interim skilled nursing care in a homelike setting in order to stabilize him for return to his home. However, only two state facilities can provide this level of care. No bed at either

facility was available for Michael for several weeks. Thus, he had to remain in the hospital, resulting in the state having to pay higher Medicaid fees to the hospital than would have been required to support his care in an interim facility.

Such child care programs are rare. Unfortunately, access to quality health care is also limited, principally because of inadequate Medicaid reimbursement.

Many health care providers refuse Medicaid patients because reimbursement levels do not cover costs. Health care services to families could be improved by increasing the level of Medicaid reimbursement to hospitals and physicians. Such a move would make prenatal, obstetrical and postnatal care a reality for those who qualify for Medicaid. As a prevention strategy for child maltreatment, the importance of making prenatal care truly available cannot be overemphasized. It is the only means for reaching families before they get in the habit of poor parenting practices that can cause severe injury.

House Bill 518 allows families with incomes at 150 percent of the federal poverty line (as compared with the usual 38 percent level used in Missouri) to qualify for Medicaid-supported prenatal care (the appendix contains the federal poverty guidelines). The Missouri Indigent Health Care Study defined the importance of helping these families in need. The policies embodied in HB 518 should be a top priority for legislative enactment because 20 percent of Missouri's children are born to families with incomes at or below the poverty line. However, abuse or neglect are not enclosed within the border of the poverty line. Early childhood health services should be supported by other mechanisms that fund health care. Traditional health insurance and alternative health delivery funding services such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs) should also support well child care. Thus, all children would be brought into the health care system at a time when early detection can identify potentially abusive situations.

Children's physical health is not being nurtured by our present system. There are several ways this could be improved. For example, in-home follow-up nursing care could be provided for infants born to at-risk families. Supporting the Parents as First Teachers program to a greater degree will make it more accessible to all families. Children need to be able to refer themselves into a safe child care setting when they feel threatened. Prenatal and well-child care should be made available to all Missouri families. Child care programs would receive a boost from increased funding for teacher training and support to the program for Missouri Voluntary Accreditation for Early Childhood Education.

Support for professionals is another key area. What can be gained from such efforts is only too evident from the following account of what a dedicated public health nurse with good training, supervision and support was able to accomplish.

Margaret

Margaret, a 24-year-old mother of two children, first visited a prenatal clinic late in the second trimester of her third pregnancy. When she missed several clinic visits, the public health nurse assigned to her case made a home visit.

There, she discovered that the three-year-old displayed severe behavior problems, and that the two-year-old had cancer. During this home visit, the nurse also learned that the mother had experienced sexual abuse at the hands of her stepfather. What's more, the woman's husband (from whom she was separated) had been an abusive parent and an alcoholic. The woman confided that she had a history of relationships with abusive men, including the one with whom she was then involved.

The nurse recognized this mother's need for assistance in problem-solving and coping

skills. Thus, she arranged for the older child to enter a Headstart program and, later, kindergarten. The nurse also maintained her follow-up with the family for several months, providing home visits and telephone contacts that fostered a close relationship between her and the mother.

This mother began keeping all her prenatal clinic appointments and delivered a very healthy child. She was also able to mobilize her personal resources and divorce her husband, obtaining child support. She ended her relationship with the abusive man with whom she had been involved.

The nurse continued her home visits and telephone calls. This mother has in turn been scrupulous in keeping the medical appointments for her newborn, securing all immunizations and meeting the well-baby appointments. She has managed to cope with the repeated crises of hospitalizations for the middle child with cancer.

No one can say for sure how much money such intervention has saved the state. But such an account clearly underscores how effective prevention efforts can be when all professionals who deal with families learn to recognize the risk factors and follow through with appropriate intervention. These types of efforts need to be strengthened.

This example also illustrates how important professionals who provide medical services can be in the overall effort to reduce the incidence of abuse or neglect. Medical care providers do not carry the same stigma as children's protective services workers or law enforcement officials. These latter groups are often avoided, understandably so, if parents fear that any interaction is likely to lead to incarceration or loss of their children. But the public health nurse, like other medical care providers, carries no such threat. Indeed, the nurse's help is usually welcomed. The nurse fulfills a key role in prevention when there is adequate training, support and supervision.

Professional support can occur in many ways. For example, school social workers or home/school coordinators could become more involved with schools and parents when identifying at-risk children. Trained and supported volunteer homemakers could revive the program of homemaker services that has been cut. Child care providers could be furnished with special training and educational resources to increase the quality of care they offer. More DFS social workers could provide this educational assistance or act as a resource for each child care center director or family day care provider. Funding these novel types of prevention is an important step.

Coordination of Care Management

In order to best meet the needs of a family, a single liaison should coordinate the activities of the various agencies and programs serving that family. Unless this coordination occurs, fragmented care will result, an outcome that is both costly and ineffective. However, a focused coordination effort can make a real difference in meeting the needs of a particular family. Consider the case of the W. family.

Mr. & Mrs. W.

Through DFS, this family adopted 11 children with special needs. The adoption of their new son Billy, age 10, was final, and the W. family was preparing to move to a rural area where they would enroll their son in school. Billy's behavior problems had been dealt with through his participation in a special class for behaviorally disordered children in the large school district he would soon be leaving.

However, the new rural school district had no such special classroom for children like Billy. Furthermore, the W. family was informed that the new school district felt that they had no legal obligation to operate such a classroom. When the W. family contacted DESE, this mistaken notion was reiterated (in fact, school districts <u>are</u> legally responsible to

provide such services themselves or to contract with other schools who can provide it).

The situation was remedied through the efforts of the local DFS office. A representative met with the W. family and the school on several occasions to discuss alternatives for Billy. Subsequently, the school and the W. family were able to discover and remedy the areas where they had failed to communicate with each other. In his new district, arrangements were made for Billy to receive classwork for the behaviorally disordered. Today, he is progressing well there.

Such coordination is, unfortunately, more the exception than the rule. Instances of fragmented care such as were cited in Part I of this report, are ineffective and costly. There are many additional cases that can be cited, such as Tom's.

Tom

Fifteen-year-old Tom has an I.Q. of about 54. When his family recognized that they were unable to care for Tom, they sought help. After an appropriate evaluation, Tom's care could have been provided by DMH. However, the juvenile courts in Missouri cannot directly place children in the care of DMH. If DMH does not take them, children must return by default to DFS. However, DFS had no appropriate placement for Tom. Since Medicaid pays the cost of a psychiatric hospital, Tom has been placed in such a facility several times at a cost of $20,000 per month.

Children like Tom, or Ricky and Kevin (whose cases were described in Part I of this report) languish in inappropriate care because no DMH facility or contractor is available. Inter-agency cooperation is desperately needed to eliminate this costly and ineffective process. Instead of being helped by our system, Tom and Ricky and all similar children are victims of it.

Lack of coordination not only prevents abused or neglected children from receiving appropriate treatment, it also fails to prevent instances of abuse or neglect. Thus, children will continue to be injured or killed.

Coordination of Programs, Including Planning

Coordination of programs can take place at several other levels. The annual statewide conference on child abuse and neglect invites representatives from child welfare, health, mental health, juvenile justice and education. But a once-a-year conference is not enough, especially for those who cannot attend. Follow-up newsletters, local sessions and persistence would bring the system up to maximal efficiency.

An important coordinative effort would be to link appropriate units of state agencies by providing reliable and consistent data for making decisions about protective policies and programs. Service groups such as the Jaycees could be encouraged to "adopt" the cause of prevention of child abuse and neglect.

> All pregnant women should have the opportunity to offer their newborn a healthy start in life.

At the community level, such efforts might entail mobilization of existing community councils or the development in targeted areas of new community groups who are geared toward prevention. With proper data on unemployment, child care, adolescent pregnancy, poverty, or child abuse/neglect reports, for example, a needs assessment could be specifically tailored to a community. Multidisciplinary teams could be organized as a branch of community councils to review individual cases, coordinating use of resources as well as ensuring effective use of existing resources such as churches. Neighborhood

support systems might include social, educational, financial and medical services.

All pregnant women should have the opportunity to offer their newborn a healthy start in life. Programs tailored to this goal would include home visits by trained home visitors and nurses, nutrition counseling, parenting classes such as the Parents as Teachers program, referrals to community agencies, and transportation assistance. Maternal and Infant Care programs would identify families who receive concentrated care following birth that includes instruction on parenting, nutrition, safety, health and family life. Respite care for high-risk parents is important, as is the development of volunteers to work in prevention programs.

Legislation

Appropriate legislation and funding will increase the chance that children will achieve their potential as they grow into maturity. Several avenues may be pursued:

- as described earlier in this report, establish the new positions of a prevention coordinator and a specialist;
- develop a plan for this state, including a legislative agenda, that establishes support services for families with children who live below the federal poverty level. These services include housing, nutrition, health care and insurance, child care, job training and literacy programs. Once these services are developed and implemented, they will help relieve the stress borne by those who live under impoverished conditions;
- enact tax incentives that would encourage employers to sponsor day care and to develop workplace policies that would foster healthy family life;
- fund programs to screen families of newborns for risk factors leading to child abuse or neglect;
- fund programs to provide for in-home follow-up by nursing and preventive social services for newborns in high-risk families;
- support appropriate measures to limit costs of medical liability insurance;
- require all child care facilities to comply with the DFS licensing rules;
- increase the number of child care openings for low income families. This would enable them to move from dependency into self-sufficiency via the labor market if child care is provided during job training, education, the transitional period between training and work, and extended for the first year of employment;
- increase the rates of child care subsidies to cover 100 percent of the cost for low-income parents in training and up to 80 percent of the cost for those who are employed;
- provide funding for child care for families living in poverty (at or below 150 percent of the current federal guidelines listed in the appendix);
- provide medical care for children living at or below 150 percent of the current federal guidelines;
- provide funding for on-going training of child care providers. One way to improve the quality of child care is to provide financial assistance to teachers who want to obtain certification as a child development associate or other formal child development training;
- ensure that non-violent conflict resolution, not corporal punishment, is practiced in all public schools;
- refine the program in child support enforcement to obtain guaranteed financial support from the absentee parent to children and the custodial parent;
- require that health indemnity provid-

ers and health maintenance organizations provide well-child care for children up to age two years;
- fund linkages between the Parents as Teachers program and other programs that provide health and social services; and
- fully fund the Parents as Teachers program.

Evaluation

This commission emphasizes the need to assess the efficiency of any program or service in meeting the needs of a family, no matter what the nature of the program or service. We have reached this conclusion following some bitter lessons learned from current programs in which evaluation was missing at several levels.

Proper evaluation can take a variety of forms. For example, the St. Louis Board of Inquiry, community-based review panel, examined child fatalities that were connected to suspected abuse or neglect. This community-based project was funded by the National Center for Child Abuse and Neglect. The board — a collection of lay and professional persons — heard testimony on each individual case from DFS, medical social workers, and physicians. Then, the board generated a thoughtful analysis, as described in this report's appendix, about how these cases were managed and how maltreatment might have been prevented.

Review panels such as the one described for St. Louis should be established in other areas, such as Kansas City, to provide an ongoing review of fatal or near-fatal cases of child abuse or neglect. These panels should include non-DFS professionals and citizens selected by the DFS director, plus representatives from DFS, law enforcement and the juvenile court, and the medical examiner. The proceedings — closed and confidential — should be summarized and the overall findings made public.

After two years, this review procedure should be evaluated and considered for other areas of DFS. Legislation may be needed to permit the open sharing of records in these confidential case reviews.

The real measure of any program is not how much is delivered in services, but how effective those services are. Outcomes of new interventions must be compared to those of current programs or services. In this way, it can be determined if such new efforts are truly preventive and cost-effective.

Instead of placing children in foster care when there is no clear evidence that they are in jeopardy, the state needs to provide social workers with discretionary funds to tide families through emergencies. Furthermore, a small expenditure for homemaking services or parenting classes would pay great dividends: families would stay together, parents would learn new skills enabling them to nurture their children, and the state would not be spending money for inappropriate child care.

B. Improve Current Service Delivery for Children and Families

Part of the ongoing evaluation should consist of scrutinizing failures. This can lead to rapid correction of faulty service delivery and help identify gaps in programs.

In order to correct some of the problems with existing programs and services provided by DFS, this commission makes the following recommendations.

1. Improve Functioning of Hotline and Family Entry into System

The operation of the hotline should occupy a high priority on the child welfare services provided by DFS because it is the entry portal for children and their families. What happens here will generally set the tone for what is to follow. Recommended changes include:
- establish uniform criteria for definitions of abuse or neglect, and con-

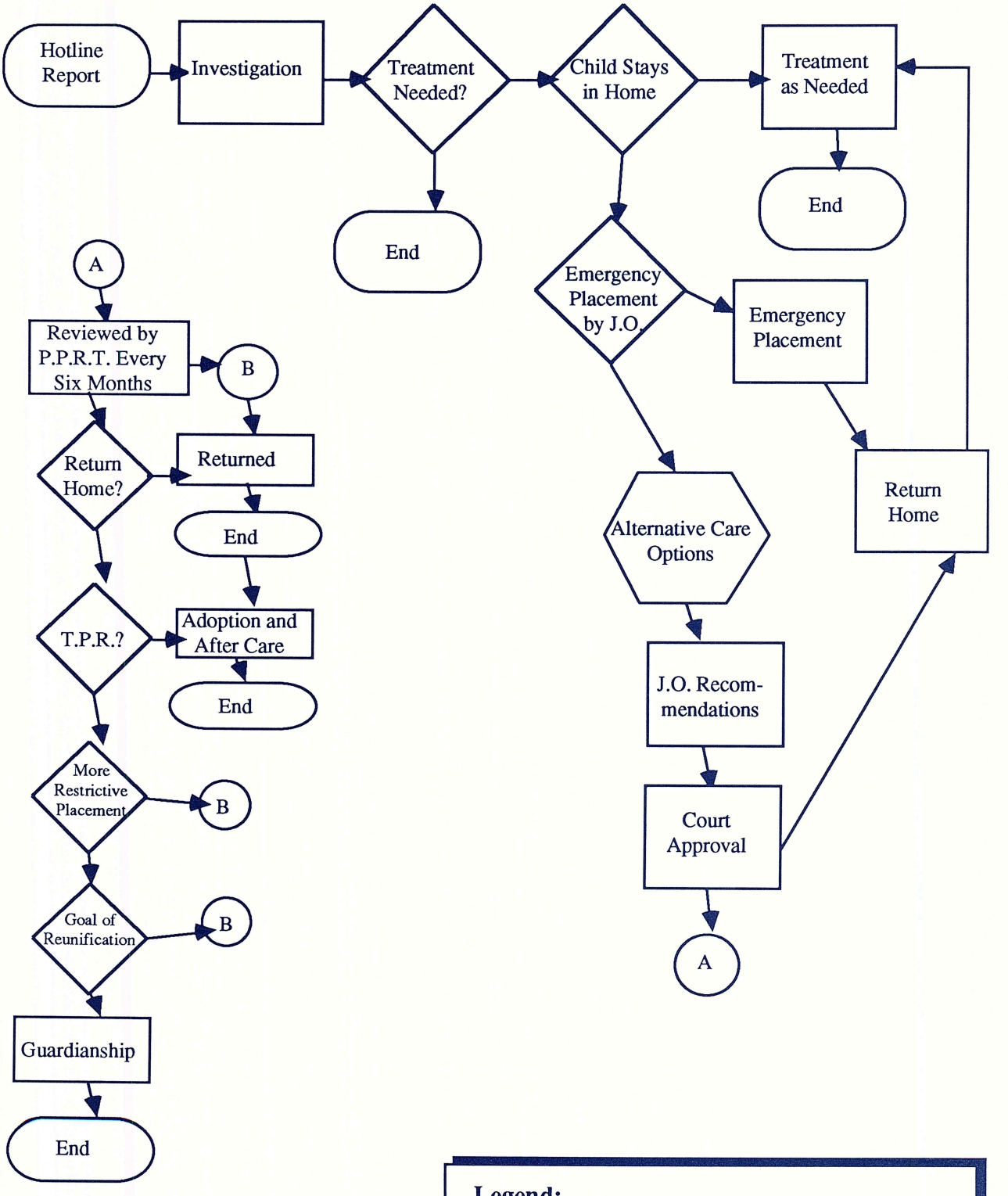
struct a rationale for opening cases. Use a quality control team to ensure that criteria are used appropriately;
- provide emergency services during the investigative period, including concrete assistance to families who are in crisis;
- develop case tracking procedures requiring that a protective service worker will contact (preferably in person) the family within a specified time period;
- conduct annual programs for professionals who are mandated to report maltreatment that would describe the operation of the hotline and how to make reports on the hotline. Create a manual with these guidelines to be given to all mandated reporters; and
- establish an accessible and timely administrative review process for those parents who do not agree with an investigative finding or who believe that the process was conducted inappropriately.

2. Provide Quality Service Delivery to Children and Families

Once children enter the system for treatment, there are several changes recommended by this commission to improve services. Initially, it will be necessary to increase funding in order to strengthen and improve the system of out-of-home placement. However, once the system is strengthened, overall costs should decrease. This reduction will occur as more comprehensive initial evaluations occur, early intervention is provided, and children are served in less restrictive settings. Recommended changes include the following:

- Provide maintenance payments to relative families providing foster care. DFS estimates that 196 children are currently in foster care with relatives and thus not eligible for maintenance payment. DFS estimates that the average cost per month for each child is $207.71. Therefore, to provide maintenance for 12 months, DFS would need an additional $489,382;
- All children placed outside the natural home should be provided with Medicaid coverage or the equivalent, no matter which state agency has legal or physical custody. DFS estimates average Medicaid monthly costs per child to be $126.06. Currently, DMH is working with the DSS/Division of Medical Services to provide equivalent medical coverage for all children in DMH facilities. However, the division does not have statistics on those children in custody of all other agencies. Therefore, making cost projections is difficult;
- All children entering the system should receive a comprehensive initial evaluation. Currently, DFS has approximately 3,500 children placed outside their own homes in a year. Estimates say that about 40 percent of these children already receive an evaluation. Therefore, 2,100 additional evaluations would incur a cost of $210,000;
- When parental rights are being terminated, all children should have legal representation. DFS recommends that an attorney be stationed in each of its six administrative areas. Two of these areas (five and six) already have attorneys. Hiring four additional attorneys and paying their salaries, including fringe benefits, equipment and additional staff expenses, would incur a yearly cost of $134,252; and
- Foster parents, including a child's relatives, should be trained before children are placed with them. Currently, DFS requires 12 hours of preservice training for all foster parents. In-service training is mandated only in Jackson County. The total cost of providing this additional training to approximately 1,000 relative foster

Movement of Children Through DFS



Legend:
J.O. = Juvenile Officer
P.P.R.T. = Permanency Planning Review Team
T.P.R. = Termination of Parental Rights

Figure 11

parents and 3,500 foster parents (including reimbursing non-DFS trainer, mileage, child care and training supplies) is estimated at $256,129 per year.

3. Keep Children Moving Through the System

The key to successful treatment is keeping children moving through and out of the system, in harmony with their individual treatment plans. Figure 9 is a simplified flowchart that shows how children placed outside their natural homes might be better served by such a dynamic system.

4. Purchase Appropriate Services

There are many remedies that would ensure appropriate purchase of services for abused, neglected and foster children:

- Establish an inter-agency committee linking DFS with the Office of Administration to review current processes for setting contracts and instituting rate structure for purchased services;
- Add evaluation staff to monitor service quality and use and to plan for future needs and cost projections;
- Use performance-based contracts with providers that tie the funding of a service to the client's achievement of the goals specified in the contract;
- DFS should develop a plan to forecast client needs and specify in the program plans the percentage of client needs being met;
- DFS should also develop a priority of services to be purchased from private agencies; and
- On a trial basis, DFS should examine the use of a flat fee reimbursement method to purchase all client services.

C. Missouri Must Adequately Fund Children's Programs

Simply spending more money will not solve the problem of child abuse and neglect, but programs must be adequately funded if they are to work. The commission's highest priorities include five recommendations. As a result, these areas have our strongest recommendations for funding. If only a small amount of money were available, the areas to start to begin to change the direction of services to abused children and their families would include the following:

- Give child abuse and neglect prevention the highest priority. Establish an executive position with the responsibility for coordinating the planning and execution of preventive services on a scale that combines the efforts of health, mental health, education and social services;
- Provide a continuum of preventive and treatment services for children and families. These services should be based on the individual child's needs and delivered in a coordinated fashion;
- Focus policy and clinical practice on preservation of the family whenever possible;
- Educate parents, children, professionals and citizens at-large for the prevention of child abuse and neglect; and
- Support programs for parents, children and professionals to prevent abuse and neglect. Programs such as the High Risk Infant Health program and Parents as First Teachers need social service support to help families where the risk of abuse and neglect is found to be high.

The lack of financial resources contributes to inappropriate placement of children in foster care and delays family reunification. To minimize this problem, we encourage the state of Missouri to establish a Family Emergency Fund that would be used to keep families together who are in financial crisis or whose financial needs are delaying a child's return home. This fund, available to a family for one

time only, would have a ceiling. Vouchers for the fund's use would provide immediate availability and ensure accountability.

D. Inaugurate Family Preservation Services

Establishing a policy whereby families are preserved, Family Preservation Services (FPS) would put Missouri in the ranks of 40 other states that have already initiated local or statewide FPS programs. This family approach is based on several assumptions: first, children need permanency in their family relationships for healthy development. Second, the child's natural family is its best primary caretaker. Finally, social service programs should help families learn to care for their children.

The primary goals of Family Preservation Services are to keep families together, to help families change violent or neglectful behavior, and to reduce client dependency on the social services system.

Although models vary among states and from private to public agencies, they have key elements in common:

- time-limited services lasting from one to six months;
- services delivered primarily in the family home;
- a mix of treatment services and concrete assistance, such as housing or employment assistance; and
- service by staff available 24 hours a day, seven days a week.

The key to this service model is intense, family-focused services.

Best of all, Family Preservation Services not only keep families together, but they are also cost-effective. Data from Washington, Iowa and Oregon show a 90 percent success rate in preventing foster care placements. These programs averaged a $2,600 cost per family — far less than the estimates of $20,000-$60,000 for placing a child in foster care for three years. Current funding trends, as shown in Figure 10, support out-of-home care as opposed to prevention and FPS. This trend must change.

E. Charge DFS to Provide a Continuum of Care Designed to Preserve Families

Ultimately, the social worker assigned to a particular case represents success or failure of an intervention. Instead of being assigned and

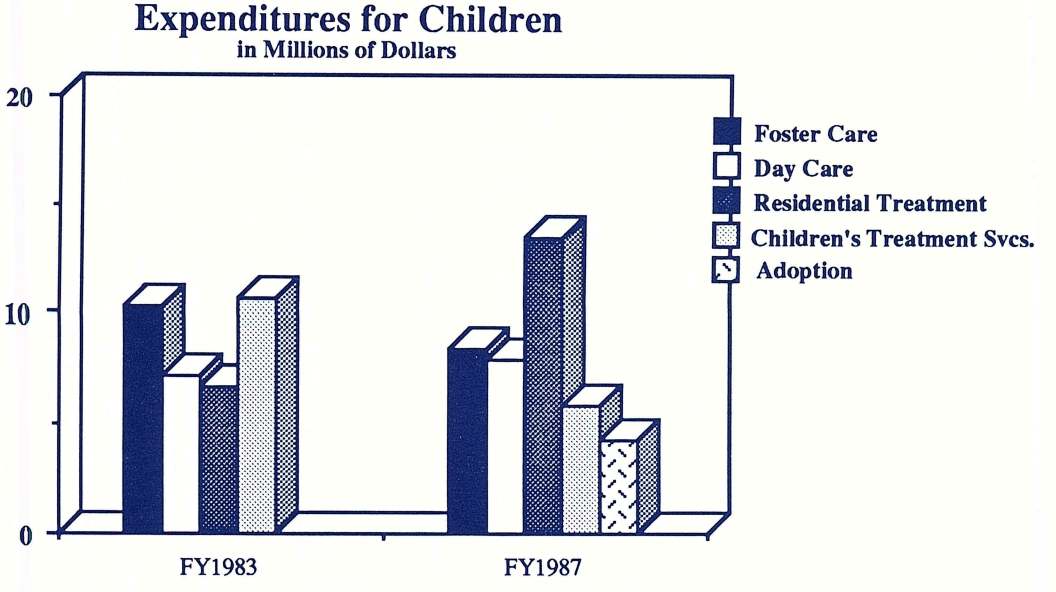


Figure 10

evaluated on a caseload of a fixed and too large of a number of cases, social workers need a new system that weighs cases according to their degree of difficulty. Such an approach should permit better service with a lower level of frustration and burnout. This commission also suggests that periodic placement audits as a function of the child's needs, or on a 30-day schedule, be conducted to help ensure children's movement out of inappropriate settings.

Staffing practices should be reviewed in the following areas:

- define the role and duties of each social service position as responsible for treatment and/or case management;
- establish a family therapist position to provide direct services and to provide consultation for other staff. This includes the provision of training that enable staff to be certified in skill areas such as marriage and family therapy;
- seek state statutes that will certify and license staff;
- provide training from experts and outside practitioners to all staff;
- require 40 hours of training for all staff each year;
- require supervisory and management staff to have on-going or yearly field experience, in addition to the above training, to continue in their position. Regardless of level, each supervisor or manager should be required to do field work with their staff regularly;
- establish a flexible schedule for employees' time to ensure the ability to respond to client needs on a 24-hour basis;
- provide adjunct resources to staff to increase the current direct contact from the present 25 percent to at least 50 percent; and
- conduct a forms audit to reduce duplication of effort and unnecessary paper work.

If the goal of DFS is to preserve the family when such an effort does not jeopardize children, the department must strengthen the very fabric of family life — fiscal, social, emotional, nutritional and vocational. Families' early participation in health, education and other services will advance this cause. To await criminal or civil court orders for client participation is to be reactive. This commission recognizes the need for DFS to assume a pro-active posture, where families themselves — not discouraged by the department's image — would request services or accept such services when others recommend them.

F. Make Organizational Changes from State Level to Grassroots

1. Assemble Advisory Committee

An advisory committee should be assembled from the groups outlined in the prevention model. This committee, chaired by the new prevention coordinator in the governor's office, should consist of the new DFS specialist as well as the in-house specialists designated from the existing staffs of the other departments.

The committee will be the core group to plan and develop prevention programs. It will also act as a clearinghouse to prevent duplication of efforts, programs or services. Most importantly, such a committee would facilitate inter-agency communication relating to child abuse and neglect prevention. The committee, with the coordinator, will provide visibility and accountability within the government for the development of prevention programs. A representative from the CTF, which was described earlier in this report, should serve as an ex-officio member of this committee, in order to share information concerning community-based programs.

2. Seed Grassroots Organizations

Although local DFS offices directly link the

branches of state government with community programs concerned with child abuse and neglect prevention, other vital resources complement and enhance this network. The Children's Trust Fund is one example. The Missouri chapter of the National Committee for Prevention of Child Abuse is a group of volunteers that works toward statewide prevention education, resource development, and an overall reduction in the incidence of child abuse and neglect. This group's activities coordinate closely with those of CTF.

In addition, a wide variety of groups — private agencies and organizations, groups of professionals and religious — contribute manpower, planning and funds to an assortment of programs and services aimed at curbing the incidence of child abuse and neglect.

Part III

A Vision for Missouri Children and Families in the Future

A. Are Families Disappearing?

Since the early part of this century, forecasters have predicted the demise of the American family. Indeed, families have changed. No longer is the norm a two-parent family with an authoritarian, bread-winning father, stay-at-home mother and grandparents who are a constant, benevolent presence. In fact, families with no children are becoming increasingly common. Many of today's families with children are likely to be headed by a single parent, often the mother.

> "Nobody's family can hang out the sign, 'Nothing the matter here.'"
>
> — Chinese proverb

One reason that the myth of the happy family of yesteryear has persisted is that as a society, we have been conditioned to hide our problems. If no conflicts marred this image of perfection, then the image must be perfect, or so went the reasoning. When difficulties did surface — an alcoholic spouse, an errant child — the problem was seen as an individual's, not as a family's.

1. Changes in Family Structure

What has deteriorated is not the family itself, but the strength of the family. Now, without an extended family to furnish support and guidance, the modern family is on its own.

Struggling and stranded, today's parents must often rear their children without the role models in their extended family that traditionally helped young mothers and fathers face the challenge of a screaming newborn or sullen teenager.

2. Changes in Societal Forces

The economic picture has also changed. The middle class is being squeezed out by the explosive growth of the lower and upper economic groups. The family with children is likely to be saddled with severe economic constraints, especially when there is only one adult in the household.

The class struggle of America's minorities remains, despite the gains in civil rights over the past two decades. These struggles will continue to shape families in the future. Although the number of white families receiving

benefits from the Department of Social Services far outnumbers, in absolute figures, those of other racial groups, these benefits are drawn by a disproportionately high percentage of black families. The state needs to be aware of this disparity and sensitive to it in its programs and policies.

Despite the myriad of old and new problems that beset families, this unit persists as the underpinning of our society; some families even flourish. Tolstoy wrote long ago that "all happy families resemble one another; each unhappy family is unhappy in its own fashion." Common characteristics of healthy families exist irrespective of factors such as income and demographics. An understanding of these traits will provide a perspective on how to begin to restore the health of families.

3. What Is a Healthy Family?

A real family is more than a group of persons who live together. People maintain their family-centeredness because they believe that sharing their existence in this way will satisfy their longing for acceptance and, ultimately, love. The basis of a family, then, rests on the ability of each member to recognize his or her deeply held feelings and describe these feelings to others in the family. A healthy family embraces its members' shared feelings, and in doing so, affirms the worthiness of each member.

Unconditional acceptance allows each family member's self-esteem to grow. This enables productive give-and-take between family members, building individual character and thus, family strength. In healthy families, members listen to one another and search for feelings hidden in verbal exchanges. The respect and trust that derive from this intimacy continue to build a sense of self-worth. There is a sense of shared responsibility and shared power that permeates the family group.

The tradition of marriage, while still with us, is no longer necessary to establish a family. Children are the visible sign — the living symbol — that men and women cling to each other for physical and psychological fulfillment, irrespective of marriage.

The rich fabric of family life is woven during the happy moments when a family enjoys itself. Healthy families are playful and display the good humor that comes from spending time working, in leisure pursuits, shared meals, traditions, and one-on-one time.

This sketch of some of the most common traits found in healthy families paints an idealized picture that no family experiences fully. But all healthy families exhibit these traits to some degree.

B. Unhealthy Families May Abuse or Neglect Their Children

The more problems a family experiences that it cannot resolve, the more likely that child abuse or neglect will result.

Child abuse and neglect are community problems. Prevention cannot be accomplished by any single agency, organization or person. Instead, it is the responsibility of the community as a whole. Prevention programs must reach children, families and caretakers before abuse and neglect occur. Prevention efforts must be integrated into accessible health, education and social service programs. To have real impact, programs must reach into individual family homes, must be coordinated and must be cost-effective.

Identifying and creating cases of child abuse or neglect are not enough, nor will it make them go away. Treatment alone does not break the cycle. In Missouri, the numbers of abused or neglected children continue to be reported in numbers that show a dramatic annual increase despite extensive efforts to treat victims and families. Simply stated, treating abuse and neglect victims — an essential component of care — is an ineffective prevention strategy.

Furthermore, any preventive efforts must be multi-faceted, flexible, and — most important — family-centered. Lack of family-centered treatment programs costs everyone dearly. Consider the case of Olga.

Olga

Thirteen-year-old Olga was removed from her natural mother at age 6. Sheltered in a series of foster homes until age ten, Olga has been living in a residential group home for the past three years. Despite apparent progress, Olga always reacts negatively to any proposed placement with an adoptive family: she regresses to an immature state, ignores her hygiene and takes months to be rehabilitated to her former self.

Since she cannot function outside an institutional setting, Olga will probably require custodial care the rest of her life, at a cost of millions of dollars. In the view of the judge familiar with Olga's case, a fraction of that amount used to stabilize Olga's home might have resulted in an entirely different outcome.

C. Is Prevention a Cost-Effective Strategy to Eliminate Abuse and Neglect?

Evidently, Americans are willing to support such preventive efforts. Based on a national survey in the summer of 1987, Louis Harris reported that "63 percent of Americans say that too little effort has been directed toward the problems of children" (page 114). Furthermore, Americans believe that government should play a central role in the prevention of abuse and neglect. The majority of Americans demand that the government provide health care for children who cannot get health insurance (90 percent) and provide day care for poor children (88 percent). In addition, Americans expect government to provide more funds for: job training for teenagers (72 percent); public schools (60 percent); prenatal care for the poor (56 percent); and children's immunizations (51 percent).

Seventy-six percent of all Americans are willing to raise their taxes to increase funding for public schools, and 73 percent would pay higher taxes to provide day care programs. What will Missourians support?

Child abuse and neglect prevention programs save lives and human suffering, but they also save money. While the overall social, cultural and environmental costs cannot be measured, the following examples illustrate the financial benefit derived from prevention services:

- Each dollar spent for good maternity care saves $3 in the first year by reducing hospital stays among babies. This dollar expenditure will save $11 over a child's lifetime by preventing permanently disabling birth defects. (Children's Defense Fund, 1987);
- Each dollar invested in the Women, Infants and Children (WIC) food program for pregnant women saves $1.42 in medical costs during the first 30 days of an infant's life (Insufficient Funds, 1987);
- Each dollar devoted to prenatal care increases birthweight and reduces premature births. When spent on prenatal care for WIC recipients — who would otherwise forgo such care in their first trimester — this dollar saves $3.38 in the cost for care for low birthweight infants (U.S. House Select Committee on Children, Youth and Families, 1984);
- Each dollar spent on comprehensive prenatal care for Medicaid recipients saves $2 in first year care by reducing infant illness and abnormalities via Early Periodic Screening, Diagnosis and Treatment Services (U.S. House Select Committee on Children, Youth and Families, 1984);
- Each dollar invested in family planning services for adolescents saves $3.76 in welfare costs for each of these young women (Insufficient Funds, 1987);

- Each dollar spent on childhood immunization saves $10 in future medical costs by reducing the incidence of rubella, mumps, measles, polio, diphtheria, tetanus, and pertussis (U.S. Select Committee on Children, Youth and Families, 1984);
- Each severe injury from abuse that is prevented saves at least $20,000 in acute medical costs (St. Louis Child Abuse Network, 1986);
- Lifetime custodial care for severely handicapped victims of child abuse is $2 million per person (St. Louis Child Abuse Network, 1986); and
- Each dollar spent on preschool education can save $4.75 in later social costs by increasing school success and employability and reducing dependency (U.S. Select Committee on Children, Youth and Families, 1984).

In summary, child abuse and neglect prevention programs save money. They also save something much more precious — our children and our future.

How can the government and private sectors afford not to work together to prevent child abuse and neglect? Abuse and neglect — expensive for all of us — cost children the most. Abuse or neglect steals from children their birthright yet to be fulfilled, as well as their freedom from fear. Sometimes, abuse or neglect robs them of their lives.

D. Improve the Continuum of Care

When preventive efforts have been ineffective, treatment must encompass those points outlined earlier in this report. Improvements in the continuum of care would mean fewer children placed in foster care or institutional care for extended periods of time. The Division of Family Services (DFS) would be far less intrusive in a family. Prompt efforts to reunify the family where parents are receiving skills training reduces family estrangement.

Intervention Works

A 1986 Child Abuse & Neglect Hotline report indicated that a Cape Girardeau family was neglecting its two preschool children and it was verified by DFS. A few weeks after the children were placed in foster care, the mother signed an agreement to seek services so that her children could be returned to her within 60 days. However, she did not complete her agreement within the specified time. DFS encouraged her to sign another agreement so that the children could be returned to her, which she did. Meanwhile, the children were transferred from a foster home to the home of relatives.

The mother once again failed to fulfill her agreement to seek services within the allotted length of time, but DFS persisted. The mother signed a third service agreement, which she also did not fulfill. DFS did not give up, and this mother signed a fourth agreement. This time, she accepted the services DFS offered her (the children had been receiving services since they were placed in DFS custody).

Subsequently, this mother fulfilled two additional service agreements. During her last agreement, DFS returned the children to the family home and made several home visits to observe the family. After being reunited for four months and continuing to receive services, this family was judged strong enough to be left alone. On September 29, 1987, this case was closed.

The DFS report indicates that this mother was very resistant in the beginning because she did not perceive that she or the children had any real problems. She also assumed that the children would return to the family home even if she did not seek the services to which she had agreed. After failing three service agreements, she finally realized that the courts were serious about keeping the children in placement outside the home until she sought help. By taking advantage of the services offered, and benefitting from them, she succeeded in getting her children back.

1. Better Delivery of Services

With the enactment of the new incentives for alternative care providers outlined earlier in this report, more and better care providers will be recruited and trained; new institutional openings will be created. Therefore, children can be placed in settings appropriate for their particular needs. Over time, this may reduce costs for alternative care and will certainly result in better relationships between care providers and DFS. There will be more professionalism in delivery of services from state departments and contractors including foster parents.

This improved public image of DFS will be further enhanced by better planning for services, which will spill over into more appropriate funding by the legislature.

2. Need for Family Preservation

Without clear, compelling evidence that children are or will be abused or neglected, families should be kept intact. Such a philosophy will help restore the failing strength of Missouri's families. Parents will learn the skills that are essential for them to hold jobs, run households, and provide nourishing food and adequate clothing. Their own self-esteem, and that of their children, will grow.

E. Results of Prevention and Improved Treatment Programs

As it spreads, the ripple effect from healthy families will help decrease symptoms of ill health that creep into all facets of our society. Restored family strength will diminish signs of family breakdown such as teenage pregnancy, drug abuse, neglect of the elderly, and involvement of the parents with the criminal justice system. Ultimately, intervention will mean less impersonality in service delivery and more emphasis on one-to-one involvement between a family and an agency. Problems such as child abuse or neglect will be regarded as family problems. Clients will not be treated as cases but as individuals in need of help.

APPENDIX

Purpose of the Blue Ribbon Commission

How well are Missouri's families being served by the Department of Social Services/ Division of Family Services (DSS/DFS)? What does this bode for families in the future, as the 21st century looms on the horizon? The broadly based Blue Ribbon Commission on the Future of Services to Children and Families was convened to address these issues. This commission consists of members from many spheres within the private sector who were assisted by Department of Social Services' staff (the list of commission members and their affiliations are listed in this appendix).

The commission recognizes that DFS strives for two broad goals for children's services. They are: prevention of unnecessary separation of the child from the parents and permanent planning for a child's placement, either with reunification of the family, adoption, or other plans.

In cases where reunification is inappropriate, out-of-home placement must meet several criteria:

- it should be in the least restrictive setting that serves the child's best interests and special needs;
- it should be as close as possible to the child's natural family yet accommodate any special needs of the child;
- siblings should be placed together when possible;
- it should be provided under contract to DFS by a licensed provider; and
- it should be with a family that closely matches the child's racial, cultural, ethnic and religious background.

Commission members gathered information that:

- examines DFS' target population so that their needs could be identified;
- evaluates the current effectiveness of service delivery to children, within and outside DFS;
- identifies gaps in the current system of service delivery to children that hinder protection of children, preservation of the family, or plans for permanent placement of children outside their natural homes;
- identifies resources currently untapped or underutilized that, if used, would enhance service delivery;
- identifies new resources that, if created, would provide the programs, funds or staff to enhance delivery of services to children;
- identifies gaps in the continuum of care and the barriers that create these gaps in necessary services to children;
- develops a long-range plan for providing services to Missouri's children and families that would prevent child abuse or neglect, promote preservation of the natural family or support its reunification, and secure permanent placement plans for children in DFS custody;

and
- evaluates the cost of obtaining effective new resources and identifies source of possible funds for them.

This commission's fact-finding examined three general areas: prevention of child abuse or neglect; services to children still with their natural families; and services for children that have been placed outside their own homes. Within these areas, the commission asked the following questions.

Prevention

✓ Should there be a specialized staff to engage in prevention efforts? Such an effort could be mounted by staff who are based in DFS facilities located in a county, area or home office.

✓ How might community councils engage in efforts to prevent child abuse or neglect? How might DFS mobilize other volunteers for this effort?

✓ How can DFS facilitate prevention of abuse or neglect by enlisting the support of other departments, e.g. the Department of Mental Health, the Department of Health, and the Department of Elementary and Secondary Education?

✓ Should DFS direct prevention efforts toward individual groups or toward the public at large?

✓ Should such efforts focus on education of the public or on the provision of concrete services, i.e. day care, respite care, crisis hotlines, etc.?

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In-Home Services

✓ How can DFS improve their delivery of services to children? Within this broad area, the commission asked which services should be:
- increased, and by how much?
- a priority?
- provided in-home rather than outside?
- delivered by DFS staff and/or private contract providers?
- provided by DFS if it were to hire its own family therapists, counselors, psychologists, psychiatrists and medical social workers?

✓ Who within DFS should evaluate the agency's vendors, and how often?

✓ How large should individual caseloads be?

✓ Should DFS institute a system whereby caseloads are weighted according to degree of difficulty before they are assigned?

✓ What is the most effective way for DFS to use volunteers?

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Out-of-Home Services

✓ Who can best screen children for such placement?

✓ How can costs be controlled?

✓ Since funds are limited, how can DFS determine which children should be served?

✓ How can DFS work better with the courts to secure out-of-home placement for children?

✓ How can DFS best evaluate their treatment services for children?

✓ Should DFS develop specialized facilities or programs, e.g. for children who have been sexually abused, who have Acquired Immune Deficiency Syndrome, or whose families abuse drugs?

✓ In order to expand the number of options for children with either special behavioral or medical needs who must be placed in foster care, should DFS purchase such care from other agencies?

✓ In order to develop resources for respite care (temporary care for families with high-needs children), what standards for care should DFS set? What constitutes reasonable reimbursement?

✓ What constitutes a professional evaluation of a child's needs, and which children need such evaluation?

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Children's Treatment Services:

Individual Psychological Counseling
Group Psychological Counseling
Family Therapy
Evaluation and Diagnosis
Home-Based Family Centered Services
Family Residential Treatment
Homemaker Services
Parent Aide
Day Treatment
Respite Care
Day Care
Resource Coordination
Transportation
Incentive Subsidy
Court-Appointed Special Advocate

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New Positions of Coordinator and Specialist

The coordinator would be someone who is well-experienced in child abuse or neglect and their prevention. In addition, this person should have the personal characteristics to be able to work with all departments within the executive branch as well as the legislative and judicial branches of state government and the private sector. The coordinator must implement an awareness campaign focused on citizen education and involvement in preventing child abuse and neglect. By definition, the coordinator's position is administrative, rather than as a hands-on service provider.

The specialist working out of DFS should be at an assistant deputy director level in the Children's Services section. The specialist must be given the visibility, accessibility and authority needed to assume a leadership role in developing, implementing and coordinating prevention programs. Among the departments identified in the organizational model in Figure 8, only DFS is legally mandated to provide services and program aimed at the prevention of child abuse or neglect. The specialist should possess the same background and characteristics outlined for the person filling the coordinator's position.

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St. Louis Board of Inquiry

This board's case reviews showed that survivors of child abuse or neglect are in every way similar to the fatal cases except for the fact that the children didn't die. This review also showed that adult males are the most common abusers of toddlers. A toddler who is slow to become toilet trained or who is "disobedient" is at risk for severe injury or death.

Another finding of this board was that young children are often the victims of whiplash or injuries stemming from shaking. Young parents do not understand that shaking a child is dangerous and need to be educated about this.

This board was particularly interested in finding out how perinatal risk factors correlated with subsequent abuse or neglect. The board found that about half the cases were high-risk, that is, there was a complication of pregnancy or a serious problem in the family. Thus, these cases could have been pinpointed for intervention and follow-up at the time of delivery, possibly preventing or reducing the severity of the subsequent abuse or neglect. But these cases never came in contact with the system again — they never received health care or social services.

Finally, the board noted that at least half of these families had some involvement with law enforcement officials or the criminal justice system, such as probation or parole. Probation officers report that they feel at a disadvantage because they lack special training to provide parental instructions to their clients or even recognize the risk factors for child abuse or neglect. Thus, probation officers — like the public health nurses, as described earlier in this report — would benefit from education and subsequent support for this training in order to help prevent child abuse or neglect.

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1987 Federal Poverty Levels
(Annual Income)

Size of Family Unit	Poverty Guideline	150% of Poverty Level
1	$ 5,500	$ 8,250
2	7,400	11,100
3	9,300	13,950
4	11,200	16,800
5	13,100	19,650
6	15,000	22,500
7	16,900	25,350
8	18,800	28,200

FIVE LEADING CAUSES OF DEATH FOR SELECTED AGE GROUPS WITH PERCENTAGES, RESIDENT DATA: MISSOURI 1986

	Causes by Age Groups	Number	Percent of Total
	Under 1 Year		
1.	Diseases of Early Infancy	370	46.3
2.	Congenital Anomalies	197	24.7
3.	Accidental Deaths	18	2.3
4.	Diseases of Heart	13	1.6
5.	Pneumonia & Influenza	9	1.1
	Total (All Causes)	799	100.0
	1-4 Years of Age		
1.	Accidental Deaths	62	43.1
2.	Malignant Neoplasms	15	10.4
3.	Diseases of Heart	12	8.3
4.	Congenital Anomalies	10	6.9
5.	Homicide & Legal Interv.	4	2.8
	Total (All Causes)	144	100.0
	5-14 Years of Age		
1.	Accidental Deaths	98	52.7
2.	Malignant Neoplasms	22	11.8
3.	Homicide & Legal Interv.	11	5.9
4.	Congenital Anomalies	9	4.8
5.	Diseases of Heart	6	3.2
	Total (All Causes)	186	100.0
	15-24 Years of Age		
1.	Accidental Deaths	479	54.1
2.	Homicide & Legal Interv.	118	13.3
3.	Suicide	112	12.7
4.	Malignant Neoplasms	34	3.8
5.	Diseases of Heart	20	2.3
	Total (All Causes)	885	100.0

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Department of Social Services/
Division of Family Services
Children's Services
Program Description

For many years, the state has responded to an expectation that it will protect and/or care for children who, for a variety of reasons, require assistance to remain with their parents or require care away from their parents. The Department of Social Services/Division of Family Services (DSS/DFS), through its Children's Services program, is one of the primary state agencies receiving referrals from the community for families and children who are in need of protection, care and services.

In recent years, growing attention has focused on children experiencing abuse and neglect. In addition, some families and children experience problems which do not meet the legal definitions of abuse and neglect, but which can be ameliorated through treatment services. Thus, DFS provides a protective service program for children and families referred because a child abuse or neglect incident has occurred, a child has committed a status offense, or a child and/or his family has experienced other traumatic circumstances.

These services are directed toward one of two goals:

- prevention of unnecessary separation of the child from the parents; and
- permanency through reunification with parents, adoption or other permanent plans.

Programs

Child Abuse & Neglect Hotline

This 24-hour-a-day toll free service is operated by DSS/DFS to accept complaints of child abuse and neglect. Receipt of a referral prompts an investigation which is underway within 24 hours and completed within 30 days. These investigations are frequently conducted and completed with the cooperation of local law enforcement personnel. The focus of the investigation is on whether abuse or neglect actually occurred and whether additional treatment and/or rehabilitation services are needed by the family and the children.

Protective Services

This program is directed toward children living in their own homes who are in danger of harm or who receive alternative care services. Service is secured and provided which will provide a reasonable effort to retain the family as an intact unit. [N.B. While placement in alternative care living situations (foster family care, group homes, residential treatment, etc.) is a discreet program providing specialized treatment and rehabilitative services, it remains an integral part of the protective services program. Alternative care services are provided for those children who must be separated from their families.]

A treatment plan is developed with the family and a wide variety of rehabilitation (both direct and indirect) services, administered by DFS and other community agencies, are used to help the family direct its own affairs and provide suitable care for the children.

To enhance this program, DFS has, for a number of years, contracted with private

agencies for the provision of specialized treatment services. These services include: family therapy, evaluation and diagnosis, day care, individual and group counseling, respite care, court-appointed special advocates, parent aide, homemaker services, home-based services, psychological or psychiatric services, adolescent group home, and residential treatment.

Safekeeping Services

While very similar to protective services in that families may receive all or a portion of the same services, requests for these services are voluntarily made by the family. Occasionally, and with the consent of the family, a community person refers a family to DFS. Information and referral services along with treatment services are offered to assist the family in providing suitable care for the child.

Problem Pregnancy Services

Information and referral service is provided to those individuals who voluntarily seek out assistance related to pregnancy. Individuals may be referred to community and medical resources and for financial assistance. In addition, direct counseling is provided to explore available options to plan for the expected child's future. These options include keeping the child or placing the child for adoption.

Day Care Services

Day care services provided by the DSS/ Division of Family Services are targeted for three groups of clients:

- children of AFDC recipients or low-income families where the child caretaker is employed;
- children of AFDC recipients of low-income families where the caretaker is enrolled in an educational or vocational program; and
- children who have been abused or neglected and receive day care services as part of a therapeutic plan.

The provision of day care services to low-income clients who are employed or in training is an important component in fostering economic independence. To be eligible for day care services, the child's parent must be receiving assistance from the AFDC program (referred to as income maintenance or I.M. day care) or meet low-income guidelines (referred to as income eligibility, e.g. day care). The parent must be employed; must be enrolled in an educational program, including high school, college, or a high school equivalency program (GED); or must attend a vocational training program. Day care is provided by licensed day care providers who have contracted with DFS to provide these services to eligible children.

In addition to allowing the parent to earn income through employment or be involved in a job training program, there are important benefits for the child. Since all day care providers participating in the program are state licensed, the child is assured of a safe, supervised setting. Young children are usually cared for in family day care homes; older children enrolled in day care centers receive the benefits of directed play and skill development associated with pre-school training. Furthermore, DFS policy requires contact with both the parent and the day care provider at least once every three months to discuss the child's progress and the appropriateness of the current day care plan, and to assess the client's continuing need for day care services.

Parents with large families or limited income have a great need for affordable day care. For other parents with few job skills, day care is a prerequisite to their being able to participate in training program which could lead to employment and economic self-sufficiency. The need for day care services is so great that the demand has sometimes exceeded the funds available. When this has happened, DFS has been been forced to maintain a waiting list and use a replacement only policy, i.e. a new applicant can be enrolled in the program only when a vacancy is created by

another child withdrawing from the program.

Day care services for children who have been abused or neglected (referred to as protective services or PS day care) are offered regardless of the parent's employment or income status. Protective services day care is only one component of an individualized case plan for the child and family. In stressful situations, day care may be used to alleviate the stress on the parent, provide care for the child while the parent attends training, or to help a child who is developmentally delayed. The ultimate goal of day care services, offered in conjunction with other protective services, is to remedy the abusive or neglectful situation and to prevent out-of-home placement for the child.

The table on this page shows DFS expenditures and the number of children served by the day care program in the last several years.

Prior to Fiscal Year 1985 (FY85), all three categories of clients were paid from either of two appropriations — purchase of day care or purchase in FY85, payment for day care services for AFDC recipients and the purchase of day care appropriation. Children who receive day care services as part of a program of protective services receive payment from the Children's Treatment Services appropriation.

Foster Care

Foster care is temporary substitute care for a child who cannot live at home with his family. The reasons a child may be placed in foster care are many and varied. Infants who have been relinquished by their parents will be placed in foster care for a short period of time until an adoptive placement can be made. Far more children, however, enter foster care because of family problems which include:

Day Care Services

Year	Total Expenditures	IM	IE	PS	POS	Total
FY83	$7,223,691	1,664	258	535	2,740	5,197
FY84	8,206,266	2,135	2,135	88	1,217	6,376
FY85	9,686,879	2,089	2,791	1,768	--	6,648
FY86	10,175,136	2,930	3,206	1,639	--	6,775
FY87 (projected)	10,960,000	1,980	3,340	1,770	--	7,090

KEY:
IM — Income maintenance clients receiving AFDC, includes clients participating in the Work Incentive program (WIN).
IE — Clients who do not receive AFDC, but who meet certain low-income guidelines.
PS — Clients receiving Protective Services day care as a result of a substantiated child abuse or neglect incident.
POS — Clients receiving day care from organizations through the Purchase of Service program; most were ineligible clients, but all three categories — IM, IE, and PS — were included in POS day care.

- the physical or mental illness of the parents;
- parental rejection;
- neglect and/or abuse;
- family breakdown; or
- behavioral problems of the child, including status offenses.

Except in emergency situations, children are placed in foster care only after services designed to prevent placement have been given to the family. Even then, children cannot be placed in foster care until the juvenile court has reviewed the case and determined that the child must be removed from the home for his or her protection.

Once in care, services are provided to the child and efforts are continued with the parents to improve the situation so that the child may be returned to the home as soon as possible.

In a small percentage of cases, the family's problems are so severe that the parents may never be able to provide an adequate home for the child. In these cases, some other plan for a permanent home for the child must be found. For most children, this means adoption or long-term placement with a relative.

Children in foster care may be placed in four settings:

- relative care;
- a foster family home;
- a specialized foster home for children with medical or behavioral problems; or
- a foster family group home.

Only children with the most severe problems are placed in residential facilities, and then only temporarily until they are able to be returned to their own homes, to function in a

Foster Care

	Expenditures			Number of Children Per Month		
Year	Foster Care*	Subsidized Adoption	Total	Foster Care	Subsidized Adoption	Residential Treatment
FY81	$6,189,028	$261,287	$6,450,315	4,937	118	500
FY82	6,140,135	496,177	6,636,312	4,512	254	552
FY83	9,338,870	809,069	10,147,939	4,233	418	564
FY84	8,451,147	1,303,382	9,754,529	4,066	648	553
FY85	9,315,531	**	9,315,532	4,024	**	720
FY86	8,256,395	**	8,256,395	3,678	**	**
FY87 (projected)	8,850,000	**	8,850,000	3,600	**	**

* Includes R&B (room and board) and special expenses for children in residential treatment from FY81 to FY85. In FY86, R&B was transferred to the residential treatment appropriation, however, special expenses for children in residential treatment were still paid from the foster care appropriation in FY86. IN FY87, special expense payments for children in residential treatment will be paid from the residential treatment appropriation.

** Service no longer paid from this appropriation.

foster family home or group home, to be adopted, or to live independently. Additional funding for treatment services is available to children in residential facilities.

Foster parents are individuals who agree to accept a child into their homes and families for a temporary period of time. They must receive training that enables them to understand the problems the child is experiencing and how to help the child. The foster parents are considered as team members along with DSS/Division of Family Services staff, the child's parents, and other professionals — all working on behalf of the child.

Foster parents are given a modest sum of money designed to cover maintenance expenses — food, clothing, toiletries, etc. — from state funds. Since Fiscal Year 1983, foster care room and board rates have risen by 26 percent.

The need for foster parents is acute, especially for certain types of children, and special recruitment efforts have been undertaken to attract individuals to the program. The first seven months of this recruitment campaign resulted in an increase in foster parent applications of 21 percent over the same period the year before. DFS has also undertaken several initiatives to ensure that adequate foster care resources are available to meet the needs of children in its care. These initiatives have included:

- the development of specialized foster homes and increased reimbursement for children with extraordinary medical needs;
- a pilot program of specialized care for children with behavioral problems; and
- a system of availability payments to foster parents who agree to accept emergency placements.

In addition, in 1985, a study of foster parents who had left the program was conducted to learn more about why foster parents withdraw and to help improve retention rates. Another survey, conducted in 1987, was directed at all active foster parents.

Residential Treatment for Children

Residential treatment is reserved for children who cannot function in a relative's home, a foster family home, or any other alternative care setting. These children have severe developmental or behavioral problems. In addition to providing room, board, and a greater level of supervision than a foster home can provide, residential facilities provide specialized treatment services designed to improve the child's psychological or emotional functioning and to bring about positive behavioral change. These services include evaluation and diagnosis, counseling, educational services, and recreational services.

Residential facilities receiving payment from DFS must be licensed. Approximately 60 facilities ranging from small group homes to self-contained campuses are under contract with DFS. In addition to the standard room and board rate paid by DFS for all children in foster care, the residential facility is paid for treatment costs on a per-diem basis. The amount of payment is based on the level of care authorized for the child (Levels I, II, III or IV) and the specialized services provided.

In October 1984, DFS established new procedures for monitoring and facilitating placements in residential facilities. Previously, Children's Services' staff had to contact each facility individually. With the establishment of the Residential Care Screening Team (RCST), the process was centralized. The purpose of the RCST is to:

- prioritize placement requests on a statewide basis;
- secure placements; and
- match the child with the facility which can best meet the needs of the child.

The RCST serves as a central clearinghouse to ensure that the neediest children are served

Residential Treatment

Year	Expenditures*	Average Number of Children Per Month
FY81	$5,413,560	513
FY82	6,580,800	544
FY83	6,649,686	565
FY84	6,459,668	554
FY85	9,465,870	734
FY86	12,655,247	836
FY87 (projected)	13,460,000	851

* From FY81 to FY85, room and board for children in residential treatment was paid from the foster care appropriation. The amount paid for room and board is included here only for FY86 and FY87.

while staying within the funds appropriated. Unfortunately, this has resulted in children having to be placed on a waiting list for residential services. In FY87, DFS requested, and the legislature approved, additional funds which will provide services to approximately 50 more children who are presently on the waiting list.

A summary of spending for residential treatment services for FY81 through FY87 is provided on the table on this page.

Independent Living Services

Assistance is provided to the child who is making the transition to adult independence. It can include individual and group counseling; locating and maintaining housing; training in daily living skills, budgeting, and use of additional education or vocational training services.

Adoption Services

This program includes assessment and evaluation of the child and his or her needs; arrangements for care of the child prior to placement; placement with an approved family; placement support activities until the adoption is granted by the circuit court; pre-adoptive and post-adoptive counseling to natural and adoptive parents regarding adoption; legal services associated with freeing the child for adoption; recruitment of adoptive families; and assessment, approval and selection of appropriate adoptive families for the child available for such placement. Additional services for the child with special needs include recruitment of appropriate families via a photograph listing service and television feature; and adoption subsidy.

This program also includes an adoption registry designed to match adult adoptees with their birth parents. Upon referral from the circuit court identifying and non-identifying background information is also secured and provided to other adult adoptees with the consent of all parties involved.

DFS adoption services are almost entirely

focused on the child with special needs who have been in foster care. However, DFS provides adoptive assessment services upon request to the circuit court and to parents experiencing a problem pregnancy.

Subsidized Adoption Program

Some children in alternative care will never be able to return home. For these children, permanent relative placement or adoption is the preferred alternative to long-term foster care. Some of these children suffer from a handicapping condition; others are older or are members of a sibling group. These factors make it difficult to find adoptive homes for these children. Frequently, these children have special needs such as the need for medical care, counseling, therapy or special educational services. The cost of caring for these children can be prohibitive for a potential adoptive family. Before the adoption subsidy program, the only alternative was to leave the children in foster care. Adoption subsidy gives the child the benefit of a permanent family while assisting the family who would otherwise be unable to adopt the child. Adoption subsidy payments assist the family by providing a monthly stipend for room and board and/or payments for special expenses which include medical expenses, day care costs, counseling fees, legal expenses associated with the adoption, special integrative expenses such as beds for a sibling group or a wheelchair ramp for a handicapped child.

In recent years, the majority of children placed for adoption by DFS have been children with special needs. The agency has devoted a large portion of its resources and placed a priority on finding homes for these children. This has enabled DFS to greatly reduce the number of children in long-term foster care, who previously had little hope of ever having a permanent home.

In addition to the specialized staff in the home office who direct the program, all DFS Children's Services staff who work with the foster care system have been involved in this effort. In February and March 1983, all foster care workers received training on recruiting and preparing families to accept special needs children. Each DFS administrative area has at least one adoption specialist assigned to the area.

What began as a special initiative to recruit families for special needs children has become an ongoing process. A partial list of some of the methods in use by DFS in this effort includes:

- establishment of the Adoption Exchange of Missouri, which also cooperates with regional and national exchanges to match children and families who reside in different geographic areas;
- One Church One Child, aimed at finding homes for minority children, was funded by a federal grant for 18 months. Although the grant expired in January 1986, the initiative has continued in the Kansas City area;
- a photograph listing of children awaiting adoption has been used successfully to make potential families aware of the needs of these special children;
- the television programs, Wednesday's Child (KTVI-TV in St. Louis and KRCG-TV in Jefferson City) and Karen's Kids (KSDK-TV in St. Louis) and Thursday's Child (WDAF-TV in Kansas City), feature children awaiting adoption for whom special recruitment efforts have been authorized;
- DFS has extended the adoption subsidy program to include children awaiting adoption who are in the custody of the Department of Mental Health, the DSS/Division of Youth Services or private child placing agencies;
- each month a waiting child is featured in the Department of Mental Health's *Developmental Disabilities*

Newsletter; and

- to gain publicity for its recruitment efforts, DFS has developed and used various other means to reach potential adoptive families including: posters featuring waiting children, informational pamphlets, bookmarks, stickers, a speakers' bureau, buttons, a toll free adoption information service (Adopt-Line), films and public service announcements.

All of these efforts have paid off in an increased number of children being placed for adoption. Since January 1983, over 2,500 children have had their adoptions finalized. Another 379 children are currently in adoptive placements. Not all of these children have needed an adoption subsidy but, for those who do, DFS has devoted an increasing amount of money to meet this need. The growth in the adoption subsidy program can be seen in the chart on this page.

Subsidized Adoption

Year	Total Expenditures	Average Number of Children Receiving Payments Per Month*	Average Cost Per Child Per Month
FY81	$ 261,287	118	$184
FY82	496,177	254	163
FY83	809,069	418	161
FY84	1,303,384	648	168
FY85	2,303,220	931	206
FY86	3,178,168	1,184	220
FY87 (projected)	4,262,000	1,450	245

* Does not include medical payments from Title XIX.

Staffing for Children's Services Programs

In the larger counties, DFS Children's Services staff are divided up along functional lines. In the smaller counties, one worker may handle several different jobs. The basic tasks of a Children's Services worker include:

- investigation of child abuse and neglect. A social service worker initiates an investigation of any report of child abuse and neglect within 24 hours of the report. The investigation determines the exact nature of the incident and the validity of the report;
- protective service. If the investigation determines that the child is in

Year	Allocated Social Service Staff* Monthly Average
FY83	1,211
FY84	1,217
FY85	1,217
FY86	1,274
FY87	1,318

danger, the worker takes immediate steps to protect the child and begins working with the family to prevent any future abuse or neglect of the child;

- alternative care. In some instances, the protection of the child requires the removal of the child from the home and placement in an alternate living arrangement. The worker makes arrangements for this placement, monitors the placement and, when appropriate, makes plans for the subsequent return of the child to the natural home; and
- treatment services. The worker obtains a variety of treatment services including counseling, residential care, parent education, day care and evaluation and diagnosis in an effort to protect the child, prevent removal of the child from the home where possible, reunite the family and prevent future abuse.

In addition to the duties related to child abuse and neglect, these staff are also responsible for authorizing and monitoring state purchased day care services for approximately 6,000 children whose parents are employed or in training and who meet low-income guidelines. A small number of staff are devoted to the Work Incentive program, which provides job training opportunities.

The Children's Services section of DFS has experienced modest gains in the number of allocated staff over the past few years.

In FY86, an increase of 68 FTE (Full Time Employees) was approved. In FY87, another 33 workers were added. In spite of these increases, the overall increase in the number of staff from FY83 to FY87 was only about 9 percent. During the same period, the number of reports to the Child Abuse & Neglect Hotline increased by almost 28 percent.

There are an additional 53 field staff involved in day care licensing and monitoring of facilities. In 1982, the Day Care Licensing Unit lost 21 percent of their allocated positions. Since then, the number of FTE has remained constant even though the number of day care facilities in the state has increased by 12 to 15 percent annually.

Comparison: Federal and Missouri Child Abuse/Neglect Law

What follows is a brief overview of the major elements of the Federal Child Abuse/Neglect Law (PL (Public Law) 93-247) with which individual states must comply in order to receive federal financial assistance. Missouri statutes (Chapter 210 RSMo) are addressed. In order for a state to qualify for

assistance it must:

- have in effect a state child abuse and neglect law which shall include provisions for immunity from prosecution for persons reporting instances of child abuse and neglect. *(The original Missouri Child Abuse/Neglect law was enacted in 1975 and amended in 1982 and 1985. Section 210.135 grants reporters immunity from civil or criminal liability for making a report, taking color photographs, making radiologic exams, or retaining of removing a child)*;
- provide for the reporting of known and suspected instances of child abuse and neglect. *(Section 210.115 provides for the reporting of child abuse/neglect by persons who have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect)*;
- provide that upon receipt of a report of a known or suspected instance of child abuse or neglect, an investigation shall be initiated promptly to substantiate the accuracy of the report and upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may in danger of abuse and neglect. *(Section 210.145 requires the division of cause a thorough investigation to be initiated immediately or no later than 24 hours. In addition, the division shall provide protective services to the subject child and to others in the home to prevent further abuse or neglect)*;
- demonstrate that there are in effect throughout the state, in connection with the enforcement of child abuse and neglect laws, and with the reporting of suspected instances of child abuse and neglect:
  - administrative procedures;
  - personnel trained in child abuse and neglect, prevention and treatment;
  - training procedures; and
  - institutional and other facilities (public and private) related to multidisciplinary programs and services as necessary or appropriate to assure that the state will deal effectively with child abuse and neglect cases in the state.

  (Section 210.145 requires multidisciplinary services to be utilized whenever possible in making investigations and providing protective social services. Section 210.180 requires employees responsible for the investigation of reports of suspected child abuse and neglect to receive 40 hours of pre-service training and 20 hours of in-service training each year thereafter. Division policy handbooks instruct staff in the proper manner to conduct investigations of child abuse and neglect and to provide services to children and families);
- provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents, or guardians. *(Section 210.150 requires that all child abuse and neglect reports maintained by the division shall be confidential)*;
- provide for the cooperation of law enforcement officials, courts of competent jurisdiction and appropriate state agencies providing human services. *(Section 210.145 requires multi-disciplinary services to be utilized whenever possible in making the investigation and in providing protective social services including the services of the juvenile officer, juvenile court, and other agencies both public and private)*;
- provide that in every case involving an abused or neglected child which results in a judicial proceeding, a

guardian ad litem shall be appointed to represent the child in such proceedings. *(Section 210.160 requires that in every case involving an abused or neglected child which results in a judicial proceeding, the judge shall appoint a guardian ad litem for the child)*; and

- provide for dissemination of information to the general public with respect to the problem of child abuse and neglect, and facilities and prevention & treatment methods available to combat instances of child abuse and neglect. *(Section 210.155 requires the division to, on a continuing basis, undertake and maintain programs to inform all persons required to report abuse and neglect and the public of the nature, problem and extent of child abuse and neglect, and of the remedial and therapeutic services available to children and their families).*

Chapter 211 RSMo establishes provisions which facilitate the care and protection of abused and neglected children who come within the jurisdiction of the juvenile court.

Comparison: Federal and Missouri Foster Care and Adoption Law and DFS Policies

This is a brief overview of the major elements of the Adoption Assistance and Child Welfare Act of 1980 (PL 96-272) with which individual states must comply in order to receive federal financial participation under Titles IV-E and IV-B of the Social Security Act. Missouri statutes and DFS policies related to PL 96-272 are also addressed.

Case Plan

Federal Statute — The state agency must promulgate policy materials and instructions for use by staff to determine the appropriateness of and the necessity for foster care placement of the child. The case plan for each child must:

- be a written document, which is a discrete part of the case record available to the child's parent(s) or guardian;
- be developed within a reasonable period of time, but no later than 60 days after an agency is awarded custody of a child;
- include a discussion of how the plan is designed to achieve a placement in the least restrictive setting available and in close proximity to the parent's home; and
- include a description of the services offered and provided to prevent removal of the child from the family home and to reunify the family.

State Statute — Section 211.183 requires in juvenile court proceedings concerning the removal of a child, that the court determine whether the division made "reasonable efforts" to prevent or eliminate the need for the removal and, after removal, to make it possible for the child to return home.

Division Policy — DFS policy requires that a case plan be developed any time transfer of a child's custody to the division is being considered. In addition, policy specifies the required components and worker activities for the case plan.

Periodic Review

Federal Statute — The status of each child must be reviewed periodically, but no less frequently than once every six months, by either a court or an administrative review. Periodic reviews should:

- determine the continuing necessity for and appropriateness of the placement;
- determine the extent of compliance with the case plan;
- determine the extent of progress which has been made toward alleviating or mitigating the causes

necessitating the placement in foster care;
- project a likely date by which the child may be returned to the home or placed for adoption or legal guardianship;
- be open to the participation of the child's parents if the review was an "administrative review;" and
- if the review was an "administrative review," be conducted by a panel of appropriate persons at least one of whom is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review.

Missouri Statute — Section 210.720 requires the division to submit a report to the juvenile court every six months for each child in its custody who is placed in foster care. Furthermore, the court shall review the report and schedule a dispositional hearing within 18 months after the initial placement and annually thereafter.

Division Policy — DFS requires that each child in its custody have an administrative review conducted every six months. Permanency planning review teams conduct these reviews. The policy specifies the participants and the content of the reviews.

Procedural Safeguards

Federal Statute — To determine the future status of the child, there must be a dispositional hearing held no later than 18 months after original placement and periodically thereafter. Procedural safeguards shall be applied with respect to parental rights pertaining to:
- the removal of the child from the home of his or her parents;
- a change in the child's placement; and
- any determination affecting visitation rights.

State Statute — Section 210.720 requires that a juvenile court hold a dispositional hearing for each child 18 months after initial placement in foster care and annually thereafter. The dispositional hearing shall be for the purpose of determining whether the child should remain in foster care, returned to the parent or guardian, or if proceedings should be initiated to terminate parental rights.

Division Policy — DFS instructs staff to seek a court dispositional hearing when a child has been in care for 18 months.

Adoption Assistance Program

Federal Statute — It requires the division to have an adoption assistance agreement which meets the following requirements:
- be signed and in effect at the time of or prior to an interlocutory decree of adoption;
- specify its duration;
- specify the amount of assistance and services to be provided;
- remains in effect if the family changes state of residence; and
- does not include eligibility requirements (means test) in determining eligibility for adoption assistance (adoption subsidy).

State Statute — Sections 453.065 to 453.073 authorize the division to grant a subsidy to a child. In addition, the statute establishes the terms and conditions of the agreement.

Division Policy — DFS specifies child eligibility requirements for adoption subsidy. In addition, DFS instructs staff on the proper procedure for negotiating payments and services for a subsidized adoption.

Alternative Care Facts

What follows is a brief, yet concise, description of alternative care programs, the

client population served, the cost of care for FY87, and the relative mandates.

Relative Care — This placement is preferred because children are normally familiar with the relative and feel comfortable in their home. The child may remain in the division's custody or be placed in the custody of the relative.

A monthly average of 532 children are served in the division's relative foster care program. The children range in age from infancy to 21 years.

A total amount spent for relative foster care during FY87 is unavailable at this time. The average monthly cost per child during this time period was $201.30.

Foster Care — This is defined as a placement with a non-relative family. Foster parents are licensed by the division for up to 6 children. The foster parents choose the age and sex of the children for whom they want to provide care. Their primary role is to provide daily care and nurturance. Under foster family group care, they can be licensed to provide care for up to twelve children.

A monthly average of 3,134 children are served in the division's foster care and foster family group care programs. They range in ages from infancy to 21 years.

A projected total of $8,959,960 was spent for foster care during FY87. The average monthly cost per child during this time period was $201.30.

Medical Foster Care — This program was developed to provide special training and reimbursement to foster parents who care for children with moderate/severe medical/mental conditions. They are reimbursed at a higher rate because they provide treatment in addition to care. The Medical Foster Care initiative was implemented in January 1985 in an attempt to prevent inappropriate institutionalization of children.

A monthly average of 38 children are served in the medical foster care program. These children range in ages from infancy to 18 years and have medical/developmental problems. The number of children served is limited by budget appropriations.

The total amount spent for medical foster care during FY87 was $300,000. The average cost per child during this time period was $295.07.

Behavioral Foster Care — This program consists of specially licensed and trained foster parents who provide treatment and care to children with moderate behavioral/emotional conditions. Foster parents are viewed as the primary treatment agents. They are reimbursed at a higher rate because of the treatment they provide. The behavioral foster care initiative was implemented in August 1985 to prevent inappropriate institutionalization of children. Currently, specialized foster parents have been trained and are ready to serve or are serving youth in the city of St. Louis and the following counties: Jackson, Jasper, St. Louis, St. Charles, Buchanan, Butler and Dunklin.

A monthly average of 43 children are served in the behavioral foster care program. The children range in ages from 8 to 16 years. The number of children served is limited by budget appropriations.

The projected total amount spent on the behavioral foster care program during FY87 is unavailable at this time. The average monthly cost per child was $345.07 for this time period.

Adolescent Group Homes — This program provides custodial care in a group home setting for children. Children placed in these homes generally do not need the treatment provided in residential centers but cannot function in a foster family home.

A monthly average of 30 children are served in adolescent group homes. They range in ages from 11 to 18 years.

A projected total of $65,000 was spent on the adolescent group home program during FY87. The average monthly cost per child during this time period is unavailable at this time.

Residential Treatment — This program is for those children who have moderate/severe

emotional and/or behavioral problems. These children normally have been unable to function in the less restrictive settings. Residential treatment is currently divided into three levels depending on the severity of the child's problems and necessity for specialized services. This year DFS has received funds for a fourth level of care. This level will provide care for children that have been unable to function in lower levels and need very intensive services.

A monthly average of 869 children are served in residential treatment facilities and group homes. With some exceptions, the children range in ages from 11 to 18 years. Due to the large number of children requiring residential care, limited availability of space in facilities, and limited funding, the division maintains a waiting list for children needing residential treatment.

A projected total of $13,582,859 was spent on residential treatment during FY87. The average monthly cost per child during this period was $1,302.

Psychiatric Hospital Placement — This program provides care and treatment for children who need short- or long-term psychiatric treatment which can only be provided in a hospital placement. Children may be placed in a private or public hospital. The cost of psychiatric hospital care is paid through Medicaid for a maximum number of days as determined by the child's diagnosis. The division pays for days of care beyond the prescribed maximum number.

Children requiring psychiatric hospitalization tend to be adolescents with serious/severe emotional and chemical dependency problems.

During FY87, the division paid for psychiatric hospital care for 42 children at a total cost of $233,962. The average cost per child during this time period was $5,570. Statistics are not readily available on the total number of children who have required hospitalization for which Medicaid paid the entire cost of care.

Emergency Care — This program provides short-term (normally 30 days or less) care for children who are just entering DFS custody or are between placements. Placement may be made in a foster home or a specially designed facility.

The children range in ages from infancy to 18 years. Emergency care is utilized for seriously abused and/or neglected children who require immediate removal from their family home, in addition to adolescents whose behavior or placement needs are such that an appropriate alternative care placement/replacement is not readily available.

Program cost is not available at this time.

Adoption Subsidy — This program is for children with special needs that may not otherwise be adopted. Adoption subsidy provides payment for such expenses as maintenance payments, Medicaid, special medical payments, and one time non-recurring expenses, e.g., legal fees.

A monthly average 1,578 children receive adoption subsidy. These children have medical/developmental problems, are members of a race or ethnic minority, or sibling group. The ages range from infancy to 18 years, however, the majority are older children.

A projected total of $4,312,551 was spent on adoption subsidy during FY87. The average monthly cost per child is $236.01

Adoption — This program is designed to provide a permanent family for children whose birth parents are unable to provide a home for him or her. The division ceases all involvement with the adoptive family at the time of the final adoption decree unless adoption subsidy is provided or post-adoption services are requested.

A monthly average of 2,091 (includes adoption subsidy) children receive adoption services. These children range in ages from infancy to 18 years.

DFS makes payments only for those children with special needs who receive adoption subsidy (see adoption subsidy for program cost).

Independent Living Program

The division has been awarded an $832,517

allotment from federal funds to allow for expansion of much needed services to youth ages 16 to 18, currently in foster care. These young people need assistance in developing the skills necessary to cope successfully with decisions related to jobs, housing and other essential areas of independent living. The independent living program is currently in the developmental stages.

Mandates

The powers, duties and authority of the Division of Family Services with regard to alternative care services are established through the following statutes:

- Chapter 208 RSMo establishes eligibility requirements for Aid to Families with Dependent Children payments. In addition, this chapter requires that such payments be made on behalf of foster children who meet those requirements;
- Chapter 210 RSMo establishes the division as the licensing authority for foster homes, residential care facilities and child placement agencies;
- Chapter 207 RSMo establishes the powers and duties of the division including but not limited is the provisions of child welfare services and social services to families and adults;
- Chapter 211 RSMo grants the juvenile courts authority to assume jurisdiction of a child and award legal custody to the division. In addition, it requires the division to make periodic reviews and reports on the progress of children in alternative care. The division is given the burden for making "reasonable efforts" to prevent the removal of a child from his or her parents and, after removal, to make it possible for the child to return home; and
- Chapter 453 RSMo authorizes the division to grant an adoption subsidy to eligible children. In addition, it establishes requirements for the termination of parental rights, appointment of a guardian ad litem, and the transfer of the custody of a child. Chapter 453 also provides procedures for disclosing adoption record information to adopted adults.

Additional mandates are found in federal law. PL 96-272 establishes requirements which individual states must comply with in order to receive federal financial participation under Titles IV-B and IV-E of the Social Security Act.

Since March 21, 1983, the Jackson County DFS office has been legally required to operate its foster care program with G.L. vs. Zumwalt (foster care consent decree). The consent decree contains a number of specific requirements designed to enhance services to foster children and their families which include, but are not limited to, the following:

- foster family assessments, training and licensing;
- preparation of the child and foster family for the proposed placement;
- frequency of worker and parent visits with the child;
- health care for the child;
- permanency planning for children;
- caseload sizes for workers; and
- uniform case records for children, parents and foster parents.

The division's compliance with the consent decree is monitored by the Foster Care Consent Decree Committee. DFS is required to submit a semi-annual report of compliance to the committee.

The consent decree only directly affects the Jackson County DFS office and their clients. However, the division has developed a statewide policy which addresses many of the requirements contained in the consent decree.